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Excellence Healthcare

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 19 January 2017 and was an announced inspection. We gave the provider 48 hours' notice that we would be visiting the service. This was because we wanted to make sure staff would be available to answer any questions we had or to provide us with the information that we needed. We also wanted the registered manager to ask people who used the service if we could contact them. At our last inspection in January 2016, the provider was found to require improvements in four out of the five areas we looked at; safe, effective, caring and well-led. During this inspection, we found that some of these improvements had been made. The provider now had safer recruitment processes and staff training had also improved. However, we found that other areas continued to require further improvements, which included record keeping and the quality monitoring systems and processes.

Excellence Health Care is a domiciliary care service which is registered to provide personal care to people in their own homes. At the time of our inspection Excellence Health Care was providing care and support to eight people.

Excellence Health Care is required to have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post at the time of our inspection.

The service was not always safe because staff did not always have the information they required to ensure that people were protected against identified risks and it was not always clear whether people were receiving their medicines as prescribed.

People's rights were not always protected because the provider was not aware of their responsibilities to ensure that care was provided lawfully. However, people were supported by staff who understood their responsibilities to ensure that care was provided with consent, where possible.

The provider had failed to respond to some of the improvements that were recommended at our last inspection to enhance the safety and quality of the service. The provider had some management systems in place to assess and monitor the quality of the service provided to people. However, some of these were not always used effectively to manage risks and to identify where improvements were needed.

People were supported by sufficient members of staff who has been safely recruited. They were also protected from abuse and avoidable harm because staff understood the different types of abuse and what actions were needed to keep people safe.

People were supported by staff who were caring, kind and respectful and who took the time to get to know them. People were encouraged by staff who understood the importance of supporting them to be as

independent as possible so that they maintained some control over their lives.

People were able to make informed decisions about the care and support they required and took a lead role in the planning of their care. People knew how to complain if they were unhappy and were confident that their concerns would be responded to.

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.

Some risks to people were assessed but not all of these had been recorded effectively to ensure that staff had the information they required to keep people and themselves safe when providing care to people.

It was not always clear that people were supported to receive their medication as prescribed.

Most people were protected from abuse and avoidable harm because staff understood the different types of abuse and what actions were needed to keep people safe.

People had their needs met reliably because the service had sufficient numbers of staff available to ensure people received the care and support they needed, when they needed it.

People received their support from staff who had been recruited safely because the employer had improved their recruitment practices since our last inspection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always protected because the provider was not aware of their responsibilities to ensure that care was provided lawfully. However, people were supported by staff who understood their responsibilities to ensure that care was provided with their consent, where possible.

People were not always supported to get their health and social care needs met, because the provider had not always liaised with external agencies when required.

Most people were supported to have enough food and drink that they enjoyed.

People's needs were met by staff that had received the necessary training to carry out their role safely.

Is the service caring?

Requires Improvement

The service was not always caring because systems and processes were not always in place to ensure care was provided to people safely and effectively.

People were supported by staff that knew them well and who understood the things that were important to them.

People were actively involved in the planning of their care.

Most people were treated with kindness, dignity and respect.

Is the service responsive?

Good

The service was responsive.

People were included in the planning and reviewing of their care so that care was delivered in a way that met people's individual needs and preferences.

People knew how to make a complaint if they were unhappy and were confident that these would be dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to respond to some of the improvements that we recommended at our last inspection to enhance the safety and quality of the service.

Systems to assess and monitor the quality of the service provided to people were not always effective at managing risks or making improvements.

Policies and procedures were not always implemented effectively or adhered to in practice.

The provider had not always ensured that improvements that were required at the last inspection had been made.

Staff reported to feel supported in their work and reported Excellence Healthcare to have an open and honest leadership culture.

Excellence Healthcare

Detailed findings

Background to this inspection

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

This inspection took place on 19 January 2017 and was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. We also wanted the registered manager to ask people who used the service if we could contact them. The inspection team comprised of one inspector.

Before the inspection, we asked the provider to complete 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. The PIR was returned within the required timescale. As part of the inspection process we looked at the information that we hold about the service. This included previous inspection reports as well as notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send to us by law. We requested feedback from the local authority and commissioners that purchase the care on behalf of people and we also contacted Health Watch, to see what information they held about the service. Health watch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection we attempted to contact all of the people and/or their relatives who used the service. We managed to speak with three people and one relative. We also spoke with two out of a possible four members of care staff who provided the domiciliary care and the registered manager.

We looked at the care records of five people, three staff files, training records, the medicine management processes, and at records maintained by the provider about the quality of the service. We also looked at some of their policies and procedures including the Whistle Blowing and Lone Worker policies.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that improvements were required to risk assessments and risk management plans; staff were not always provided with clear guidance nor did they have access to the relevant guidance when they were in people's homes on how to support people who were at risk, for example, of falls. During this inspection, we found that these concerns had not been addressed. We also found that risk assessments we looked at were not always specific to people's health related care needs and did not always reflect the information that had been provided in the social worker's initial assessment. For example, we saw that one person was reported to present with behaviours that are described as challenging, such as verbal aggression, due to their health condition. However, this information was not included in their risk assessment or care plans and there was no guidance to staff on how they could support the person to manage or prevent these incidents from occurring. People we spoke with did not raise any concerns about the impact that this lack of information had had on the care that they received and staff told us that they visited the same people regularly and therefore did not necessarily rely on these records because they got to know people well. This meant that this lack of information had not had a negative impact on the care that people received. However, if a new member of staff was deployed to provide care to a person they were unfamiliar with, they would not always have the information they needed to ensure people's needs were met safely. We discussed our concerns with the registered manager at the time of our inspection. The registered manager acknowledged the continued shortfalls and assured us that they would review and update all of their care plans and risk assessments before taking on any more care packages and that they would let us know when this had been done.

Some of the people and/or relatives we spoke with told us that the staff supported them (or their relative) to take their prescribed medication. One person told us, "I mostly do my own medication but they [staff] will check that I have taken what I needed to, in case I have forgotten if I am having a 'bad' day". Another person said, "I know I could have help with my medication if I needed it, but I am okay". We saw that the provider had a medicines policy and people had care plans and generic risk assessments in their care records about the level of support they required with their medicine. However, these were not always sufficiently detailed to ensure people received their medicines safely. For example, we looked at one person's medicine regime more closely and found that their care plans or risk assessments did not detail how their medicines should be administered and by whom, when or how often. It was also not clear from looking at the persons records and by speaking with the provider, the person's relative and staff individually, whether this person was receiving their medicines safely, because they all gave different accounts of the person's medicine routine. We discussed with the registered manger that staff may need further support in the administration of medicines. We asked the registered manager to explore this with the member of staff as a matter of priority.

From speaking with the relative, we also found out that although the registered manager had told us that the medicines in question were given "when required", they were actually prescribed to be given regularly to control the persons symptoms. We were told the [person], "Doesn't always get it through the night when [staff] are here because they don't like giving it". This meant that staff were not following the correct procedures in place to ensure that people received their medicines safely and as prescribed. The records did not support the safe administration of medicines and the registered manager had not ensured that they

were clear on what was required or expected of staff when they agreed to provide the care package to this person. We fed our concerns back to the registered manager at the time of our inspection. They assured us that these issues would be addressed as a matter of urgency and agreed to show us that this had been done.

During our discussions with relatives, we identified a potential safeguarding issue that we referred to the local authority, who are responsible for investigating safeguarding concerns. We also shared the concerns that had been raised with us, with the provider. The provider took the appropriate action to protect the safety of the person whilst safeguarding investigations were underway. They have a legal responsibility to keep us informed of the outcome of these investigations.

When we asked staff about their understanding of safeguarding vulnerable adults, all of the staff we spoke with knew what was expected of them in order to keep people safe from abuse and avoidable harm, including what the reporting procedures were. They were aware of the different categories of abuse including physical abuse, financial abuse and neglect and what signs they would look for if they suspected someone was at risk of abuse. One member of staff told us, "If someone did not appear themselves or if I saw marks on their body or money had gone missing for example, I would contact the manager; but I know I have a responsibility too, so if he didn't respond to it, I would call the safeguarding team or CQC myself". Information we hold about the service confirmed that since our last inspection, we had received a notification of reported allegations of abuse from the provider. This meant that the provider had acted appropriately when they were aware of concerns, in order to protect the safety of people who used the service and was aware of their reporting responsibilities.

At our last inspection we found that the provider was not always following robust recruitment processes. We found that improvements had been made. Staff we spoke with and files we looked at confirmed that the provider had completed a range of employment checks including a formal interview, references, and a Disclosure and Barring check. The Disclosure and Barring Service (DBS) helps an employer make safer recruitment decisions and reduces the risk of employing unsuitable staff from working with people who require care. This corroborated the information that the provider had shared with us in the Provider Information Return (PIR) form prior to our inspection.

Overall, most of the people we spoke with told us they felt safe receiving care from Excellence Health Care and records we looked at showed that people were consistently satisfied with the care they received. One person said, "I definitely feel safe, they are excellent". Another person told us, "They [staff] are very good at what they do; they are well trained, so I know I am safe". Staff we spoke with told us that they knew how to keep people safe. One member of staff said, "In an emergency I would call 999. If I found someone on the floor for example, I would call 999 immediately, make sure they were responsive, make them comfortable but try not to move them; keep them warm and reassure them until the ambulance arrived". Another member of staff told us, "I have a lot of passion for caring and looking after people so I must ensure they are safe and protected; any concerns and I would report it immediately to the manager".

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that staff involved them in making choices and decisions about their care in accordance with the Mental Capacity Act (2005). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. One person told us, "They [staff] always ask me before doing anything, so it is always with my consent". Another person said, "They [staff] are very respectful, always talk to you and ask you before doing anything". Records we looked at showed that staff had received training on the MCA (2005) and staff members we spoke with were able to explain to us how they ensured care was delivered with consent. One member of staff told us, "We always make sure we talk to people and help them to tell us what they want/need us to do; if we are unsure and they aren't able to tell us or consent, we can speak with family or refer to care plans to know their needs and provide care within their best interests". Another staff member said, "I have done care for over 20 years so I have a lot of experience in being able to adapt the way I communicate with people to enable them to consent if possible; but if not, we look after them in their best interests".

However, staff we spoke with including the registered manager were not always aware of what action they needed to take to protect people from the risk of having their liberty deprived if they lacked the mental capacity to consent to care, despite having received training. The Deprivation of Liberty Safeguards (DoLS) requires providers to identify people who they are caring for who may lack the mental capacity to consent to care and treatment and their liberty may be being restricted. They are also required to notify the local authority of this, so that an application can be submitted to the court of protection for the authority to deprive a person of their liberty within the community in order to keep them safe. The provider was unable to articulate their understanding of DoLS and was not aware of their reporting responsibilities. We saw that they were providing care to people who had been assessed to lack the mental capacity to consent to this care. Records we looked at showed that one person was receiving personal care and constant supervision, either by staff or family members, to ensure their needs were met and to prevent them from leaving the house in order to keep them safe. The registered manager had failed to identify that this was a potential deprivation of the person's liberty and had not informed the local authority, who would have the responsibility for making an application to the court of protection to get the authorisation to continue to provide this care lawfully. The registered manager recognised that an additional training session on DoLS in the community would be beneficial to all members of staff including themselves and assured us that they would act accordingly with regards to the concerns raised above.

At our last inspection, we found that the provider had not ensured that people received their care and support from staff who had received adequate training. This meant staff did not always have the knowledge and skills they required to do their jobs safely and effectively. Before our inspection, we looked at the information the provider had shared with us in the Provider Information Return (PIR) form. This stated, "Our staff now receive all mandatory training and in addition, any specialist training needed for the purpose of meeting the needs of service users". This was corroborated during our inspection; we found that

improvements had been made and that staff now had access to a comprehensive training programme, including an induction programme. New staff were now also required to shadow experienced staff and have a competency check before working unsupervised; this was then followed up with spot checks. The registered manager told us that this ensured staff had the knowledge and skills they required to care for people safely.
People we spoke with told us that the staff who provided their care seemed to have the knowledge and the skills they required to do their job. One person told us, "They [staff] are excellent; very skilled, they know exactly what they are doing and what I need". Another person said, "They must have very good training because they are very good". Feedback we received from a company who use the staff from the care agency to cover staff shortages in their service told us, "Excellence Health Care is the only agency we use; to date, we have always received an excellent and professional service from this company; the staff are well trained and always provide us with the training information that we request [about the staff members] and any training issues we have identified have been dealt with quickly". Staff we spoke with and records we looked at confirmed that staff had received sufficient training in order to provide care to people safely and effectively. One member of staff said, "We are well trained, initially we had the induction and core training as well as shadowing, and then we have done additional training and [registered manager] always makes sure we are kept up to date".

Staff we spoke with told us that they felt supported with day to day issues and that there was always someone available to offer help and advice. One member of staff said, "I do feel supported, I can always ring [registered manager] if I need to". They told us that they received planned supervision sessions with the registered manager and that the provider also arranged team meetings. Records we looked at confirmed this.

We found that most people were supported to have enough of the food and drink that they enjoyed. Records we looked at showed that staff were required to support people with meal preparation and were also instructed to make sure food and drinks were easily accessible to people, in case they became thirsty or hungry in between their planed home care calls. One person told us, "They support me with breakfast and a hot drink; it's always my choice what I have". Another person said, "On a bad day, they don't always have enough time to support me with my meals, but they do stay over to help; I am hoping to get this reviewed". We saw that this had been mentioned in the person's care review but had not been followed up by the provider. The registered manager told us that this was mentioned to support the person's application for a benefit that people can receive to help them to pay for their care, but agreed that the person needed a review from the local authority too and that they would make a referral immediately.

Records we looked at identified people's likes and dislikes and staff we spoke with told us how important it was to offer choice. One member of staff said, "I always ask what people want to eat to give them the choice". Another staff member told us, "Some people will show us what they want by pointing or taking us to it, if they can't speak". We were told that at the time of our inspection, the service was not providing care to people with complex care needs with regards to their dietary requirements. However, records we looked at showed that where people did have particular dietary needs, this was not always reflected in their care plans or risk assessments. For example, a social worker had instructed that a person required their food to be finely cut and hot drinks not be served too hot due to the risk of burning; this did not form part of the persons care plan or risk assessment. We fed this back to the registered manager at the time of our inspection, who assured us that these records would be reviewed and updated to ensure pertinent information, such as this was included.

During our inspection, we asked the registered manager how they supported people to maintain good health and have access to healthcare services. They told us that they encouraged people to visit their GP if

they noticed any changes in their health and would also liaise with health and social care professionals where required. The registered manager gave an example of how they had contacted the continence team for one person and had also contacted wheelchair services for a re-assessment of another person's needs. However, one person we spoke with told us that they had tried to apply for a specific allowance/benefit to enable them to pay for an increase in the care package that they were receiving. They told us that they had not received any assistance from the provider with this. We saw that this person had told the provider during a care review that they required additional time and support, but it was not clear what action had been taken. The registered manager told us that this was only mentioned in the context of them applying for the allowance which was something the person was doing independently. However, they agreed that they should have offered some assistance by contacting social services to see if this persons needs could be reassessed. Records we looked at showed that this persons care calls were taking longer than the agreed time that had been commissioned, which was reflective of their changing needs and that a re-assessment was likely to be required. The registered manager told us that they would arrange this as soon as possible.

Requires Improvement

Is the service caring?

Our findings

We found that the service was not consistently caring because the provider did not always have robust systems and processes in place to ensure that the care people received was delivered safely and effectively. However, most of the people we spoke with recognised that this was an organisational weakness rather than a reflection on the individual staff members; they told us that they were mostly happy with the staff that provided their care.

Information shared with us by the provider in the Provider Information Retrun (PIR) form told us that when they recruit staff, they draw up a person specification that includes key personal qualities which are desirable for the job. These include; kindness, caring, compassion and respect for others. People and relatives we spoke with told us that the staff who visited them were kind, friendly and caring. One person told us, "She [staff] is very friendly, very nice and caring". Another person said, "They [staff] are very good, very friendly and very good at what they do". A third person said, "They [staff] are all lovely; my carer is lovely, the manager is lovely". A relative we spoke with said, "Generally she [staff] is a really nice person, very kind and caring; we all like her, [person] likes her".

Everyone we spoke with also told us that they were pleased with the consistency in the staff that provided their care. One person told us, "I have one carer, it's always the same lady, and she is very good". Another person told us, "It's always the same person, so you get to know each other; it's very good". A relative told us, "The consistency is good, and despite the issues, [staff] is very good with [person] most of the time; we really value having her here because it gives us a break". Staff we spoke with told us how they developed positive relationships with the people they cared for. One member of staff told us, "We get to build almost friendships with people because we see the same people all the time; we keep it professional obviously but I think it's nice to have that relationship; it makes it more personable". Another member of staff said, "I like my job, I enjoy caring for people; I get on well with people and their families".

We found that people were supported to be independent. One person told us that they liked to do a lot for themselves and that staff only helped them with the things they couldn't manage. They said, "I am very independent; for instance, when they [staff] are helping me with washing and dressing, they will do as much or as little as I need them to; depending on how I am feeling that day". Care plans we looked at promoted people's independence. For example, one care plan read, "[person] is a very independent man and will do as much as he can for himself; he will give clear instructions on the level of support he needs on a daily basis". Staff members we spoke with were able to tell us how they promoted people's independence. One member of staff said, "It is important to promote independence and encourage people to do what they can".

People told us and records showed that people were actively involved in their own care and they felt listened to. One person told us, "I was involved in planning my care and my friend also supported me with this and they listened to both of us". Another person said, "They [staff] make sure everything is okay". Care records we looked at showed us that some people had received a telephone call to review their care and other people had completed a review questionnaire.

Most of the people we spoke with said that the staff treated them with dignity and respect. One person said, "She [staff] is very good at minding my privacy; she talks to me and offers reassurance". Another person told us, "It [care] is very respectful, especially in terms of my personal care". They gave us an example of how staff will assist them to undress, but will leave them with their underwear on for them to remove themselves in order to protect their privacy and dignity. Staff we spoke with were mindful of people's rights to have their privacy and dignity respected. One member of staff told us, "It's important to keep it [personal care] private as well as peoples' personal information". Another staff member said, "When we are washing and dressing somebody, I make sure all windows and doors are closed to keep it private and I'd never let anyone in the room unless they wanted them there". We also found that staff maintained people's dignity in other way such as by respecting their preferences and promoting their independence.

Good

Is the service responsive?

Our findings

Information we received from the provider in the Provider Information Return (PIR) form told us that people and/or their relatives engaged in an initial assessment and regular care reviews to ensure that the care being provided to people was person-centred and met their needs. We found that people were receiving personalised care that was mostly responsive to their individual needs. One person told us, "They [staff] know exactly what I need and what I like, and that's what I get". Another person said, "She [staff] is very good; she does everything I need her to do and more, sometimes". A relative told us, "My brother was involved initially in the assessment to make sure they had all of the information they needed; and when we needed changes made, these were put in place; it's been very good". Care plans we looked at were person-centred in parts, although some were seen to lack pertinent information about people's cultural and diverse needs, social interests and personal relationships. We were told that this was because the care package being provided did not include any care support that was required to meet these needs specifically. However, the provider recognised that in order to provide a holistic and person-centred service, staff should be aware of the person as a whole to enable positive relationships to form. Thus, staff should have access to information about what and who is important to people.

The registered manager told us that there was a complaints procedure in place and they had not received any formal complaints since the service became registered in 2015. People we spoke with knew how to complain and told us that the complaints procedure was included in the care manual which was given to them when they joined the care agency. One person said, "I have not made a complaint, but if I had any concerns I would call the office". Another person told us, "I have no complaints, but I know I can call the manager; they are lovely". A relative told us, "I know my brother has raised some issues with [registered manager] in the past and these have always been resolved; but overall, we haven't had cause to complain, really". Everyone we spoke with told us that they were confident that any issues they did have would be resolved quickly. This was evident during our inspection; the provider had responded immediately to the concerns that we raised with them.

People told us that they were mostly satisfied with the care they received and that the service was responsive to their needs. One person told us, "They are very responsive to changes; all I have to do is text or email and they respond immediately and always accommodate my requests; it's excellent". We also saw that despite not arranging a re-assessment with social services to increase a person's care package formally, the provider had recognised that a person's care needs had changed and care staff had accommodated their additional needs by extending the duration of the care calls to ensure their needs were met. The provider recognised that this was not ideal because they were not being commissioned for this extra time. They also acknowledged upon reflection that it was their responsibility to support the person to request a re-assessment; they assured us that this support would be provided

People we spoke with told us they would recommend Excellence Healthcare to others. One person said, "They are brilliant, I would recommend them to anyone". Another person told us, "I am very satisfied, I would definitely recommend them". A professional from another service provider said, "I would have no problem recommending this company to other service provider's or people".

Requires Improvement

Is the service well-led?

Our findings

The service was required to have a registered manager in place as part of the conditions of registration of the service. There was a registered manager in post at the time of our inspection.

We found that since our last inspection some improvements had been made to address some of the shortfalls we had identified. However, further developments were required because the provider had failed to respond to some areas of our feedback at our last inspection. For example, during the inspection we continued to find shortfalls with insufficient and unspecific risk assessments and care plans, the provider's limited knowledge and understanding of the Deprivation of Liberty Safeguards and Duty of Candour as well as shortfalls within the quality monitoring systems.

At our last inspection, we found that policies and procedures were in place to guide best practice; however some of these lacked detail and were not always being implemented or followed effectively. This continued to be an issue during this inspection, including the concerns raised last year with the lone worker policy. Again, we found that the lone worker policy referred to an 'on call' system and that staff should inform the on call personnel that they were safe and well at the end of their shifts. The registered manager told us that there was no 'on call rota' because he was always 'on call'. However, not all of the staff we spoke with were aware of this process and they told us that they tend to only call the registered manager if they needed to. We did not see any staff safety monitoring records such as signing in logs, which showed us that the registered manager had actively implemented the lone worker policy by keeping track on when staff had informed him that they were safe and well at the end of their shifts. This meant that if a member of staff was harmed, injured or missing and was unable to make a telephone call, no one would know they needed help, leaving staff and people at risk. In addition to this, at our last inspection we found that the provider's whistle blowing policy did not provide contact details of external agencies such as CQC or the local authority. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. These details were still found to be missing from the policy during this inspection. However, staff had now received training in this area and staff we spoke with told us that they felt comfortable raising concerns with their manager and were aware of the external agencies they could contact if they needed to.

At our last inspection we asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was unable to tell us of their understanding of this regulation. During this inspection, the registered manager continued to have difficulty recalling their understanding of this requirement. However, following our explanation of the regulation, the registered manager assured us that they were compliant with this regulation in their work. They told us that they were open and honest with their staff and with people who use the service. Staff we spoke with told us

that the registered manager is approachable and that communication was open and honest within the service. Records we looked at showed examples of how the registered manager had upheld their responsibilities in this area. For example, we saw that following our last inspection, the registered manager had contacted all of the service users to share the outcome of the inspection with them and was open and honest about the improvements that were required. Information we hold about the provider, showed that they had submitted the relevant notifications and had kept us informed of events and incidents that had occurred within the service, as required by law. We also found that the registered manager was co-operative and transparent during the inspection process.

We saw that there were some systems in place to monitor the quality and safety of the service, and that some of these were used effectively, including staff spot checks and the monitoring of staff recruitment. However, some of the systems and quality audits were not always used or recorded effectively. We saw that audits did not identify the shortfalls we found during our inspection. For example, audits of the care records did not identify the issues relating to medication care plans, risk assessments or protocols. We found that these records were not always sufficiently detailed to ensure people received their medicines safely. Care plans or risk assessments did not detail how the medicines should be administered and by whom, when or how often. For example, the registered manager told us that one person was prescribed medicine on a 'when required' basis. They registered manager said that staff were not authorised to administer some of the medicines, and instead, staff would need to let the person's relatives know that the person needed the medicine so that they could administer it themselves to the person. This was not clear in the person's care records and we could not see a protocol, risk assessment or care plan that included this information. Where information was available it was not always clear. For example, we saw information in one person's care file stated the name of a medicine, followed by, "One tablet; if worn off after one hour; we are not always administering". There was no guidance on why this may be, or in what circumstances it should be administered after one hour or whether there were any other ways of supporting this person if their symptoms remained uncontrolled. Details of potential side effects of the person's medicinces and what action should be taken if such effects occur were also omitted from the records.We were also told that staff could administer medicines from a blister pack, but it was not clear what these medicines were. Staff signed an administration record to show medicines had been given but these did not indicate if family members had administered any of them as suggested by the registered manager. The registered manager told us that the staff member may be signing on behalf of the family, but this was not an accurate record of administration. This meant that Medication Administration Records (MAR) charts did not utilise the key code appropriately, lacked detail and did not appear to follow protocol in accordance with the person's care needs, all of which had not been identified or addressed with staff by the registered manager.

We also saw that checks on the daily records and staff time sheets had not identified concerns relating to people's changing needs. For example, the duration of one person's care calls was consistently exceeding the commissioned and planned time and they had informed the provider that they required further assistance in the morning, but no action had been taken or recorded to follow this up with social services. We also saw that the daily record logs consistently reported a person to be complaining of persistent pain, despite the administration of medication and that staff appeared to be struggling to meet the needs of this person. This had not been identified by the provider. They had not discussed this with the person and/or their family, or liaised with other health or social care professionals to consider whether a medication review was required, nor had they offered support or supervision to the member of staff to ensure they were effectively managing on both a practical and emotional level, to support the person with their complex care needs.

Where quality monitoring had been facilitated; there was a general lack of qualitative data and analysis of this information to provide any substance or allow for any comparison of the information collected. The

records did not show what action had been taken, if any and why, and it was not clear how this information had been used to drive improvements or to monitor the effectiveness of any changes that had been implemented as an outcome of the quality monitoring processes. Examples of this included a log sheet of feedback received from people which had been collected from telephone calls made to service users. This had not been analysed, quantified or themes/trends identified to allow the provider to use this information comparatively in the future. We also saw that one person had provided feedback, on two separate occasions that gave different ratings about the quality of the service provided. There was no evidence that this had been explored or followed up by the provider, or that any action had been taken to try and improve the service to raise the rating again.

Collectively, this is a breach of regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 relating to the lack of governance within the service. You can see what action we have asked the provider to take at the end of this report.

Staff we spoke with told us and records we looked at showed that they received regular supervision. Staff told us that the communication between management and staff was open and transparent and that they felt involved and well informed of any changes or developments within the service. One member of staff said, "I can contact [registered manager] at any time and I know he will be happy to help". Another member of staff said, "I have regular telephone contact with [registered manager]; he is very approachable".

Before the inspection, the registered manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. Most of the information provided within the PIR was corroborated throughout the inspection by the observations we made, records we looked at and by what people told us. However, the PIR did not demonstrate the provider's recognition or awareness of the shortfalls identified during the inspection.

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 17 HSCA RA Regulations 2014 Good governance We found that some of the shortfalls identified at our last inspection in January 2016 had not been addressed. We also found continued shortfalls within the provider's quality monitoring systems which meant they had failed to identify further shortfalls found during this inspection, including poor record keeping.