Key 2 Care Limited

Derbyshire Care Services

Inspection report

25 Shardlow Road
Alvaston
Derbyshire
DE24 0JG

Tel: 01332275060
Website: www.derbyshirecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over 20, 21, 22 and 30 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. Phone calls to people were completed on 20 and 21 June 2017 and we visited the premises and spoke with staff on 20 and 22 June 2017. Phone calls were made to more staff on 30 June 2017.

The service provides personal care and support to people who live in their homes in and around the Derby area. The service operates from two locations, one at Burton Road and one at Shardlow Road. This inspection relates to the service provided from Shardlow Road to people living in and around the south of Derby; at the time of this inspection 117 people received the regulated activity of personal care from the Shardlow Road location.

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

Although people felt care staff helped them reduce risks on a day to day basis, care was not always safe as risk assessments and care plans were not always updated in a timely manner. Nor were risk assessments always complete. In addition, risk assessments were not in place for all areas of risk to a person and to staff.

Not all steps had been taken to check people recruited to work as care staff were safe to do so. Not all pre-employment checks designed to help providers make safer recruitment decisions had been completed as required.

Although staff told us they were confident at identifying some of the signs that could indicate abuse to a person and told us they knew how to report their concerns, we found the training material they were given did not reflect the current types of abuse recognised in safeguarding practice. Not all allegations of abuse had been sent to the local authority as safeguarding referrals.

People did not experience missed calls, however some people experienced late calls and people did not always get a phone call to let them know if a call had been delayed. People did not receive information on what care staff would be supporting them each week. People told us they appreciated regular care staff; where people did not receive regular care staff they felt their care was compromised in a variety of ways. There were a sufficient amount of staff to attend to calls, however staff were not always deployed in ways to ensure people felt safe and knew who was coming into their home.

The MCA had been considered when assessing people's capacity to consent to their care. However where people were identified as not having capacity there were no records of best interest decision making to

show the care provided was in the person's best interests. Staff knowledge on the MCA varied and not all staff had been trained in this area. Records showed training in other areas relevant to people's care had not been consistently completed by all staff.

Records of people's care were not always accurate, complete or up to date. Care plans and risk assessment records were not audited to ensure the quality and safety of records.

Statutory notifications were not always submitted as required. Not all actions were taken to ensure improved services to people. In addition, people had been asked for their views; however they were not informed of what actions would be taken to improve the service based on their feedback. People had not always experienced improvements as a result of sharing their views.

People felt they could complain and if they had done so they felt they had received a response and things had improved. Whilst we saw actions were taken to people's individual complaints, there was no evidence to show how actions were being taken to improve the service for people based on themes emerging from people's complaints.

People told us they felt involved at the start of their support when the care plan was developed with them. However some people told us, and records confirmed, they did not always contribute to on-going reviews of their care.

People told us they had mixed experiences of being supported to access other healthcare services as required.

Guidelines were in place and followed to ensure medicines management and administration was safe.

Staff told us they felt supported by the registered manager and received feedback that helped them identify how to improve their practice.

People received care to enable them to have sufficient food and drink of their choice.

People told us most care staff were friendly and respected their privacy and promoted their dignity and independence. People were happy care staff were respectful to their home. People's cultural views and values were known and respected.

There was a registered manager in place at the time of the inspection. Staff told us they found the registered manager and director approachable. People and their families told us they had no problem contacting the office with any queries. Staff told us they enjoyed their job and had opportunities to meet with the registered manager to share their views.

Spot checks were made on the care provided by staff. Phone calls were made to people when they first received care from Derbyshire Care Services and for a period of time thereafter to check they were happy with the service received.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we asked the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were not always up to date, complete or had been updated in a timely manner. Safeguarding referrals had not always been made for allegations of abuse. People did not always feel safe as they did not always know the care staff member providing their care. Not all pre-employment checks were completed to ensure the provider made safer recruitment decisions.

Sufficient staff were available to attend calls, although people were not always advised if their call was delayed. Procedures were in place, and followed, for the safe management and administration of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Policies were in place so people's care could be provided in line with the Mental Capacity Act 2005 (MCA) if they lacked the capacity to consent to their care; however best interest's decisions for people's care had not been recorded. Not all staff had been trained in the areas identified as relevant to people's needs. People had mixed experiences of being supported to access other healthcare services.

Staff felt supported by their managers. People were supported to have good health and nutrition.

Is the service caring?

Good

The service was caring.

People felt most staff were friendly and respected them and their home. People felt staff promoted their dignity and independence. People were involved in planning their care when the service started and their views and decisions were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people felt involved in on-going reviews of their care. It was not always clear what actions the service had taken to improve services to people based on themes emerging from complaints.

People's preferences were known and respected. People knew how to raise feedback or complaints. People felt if they had complained this had been responded to and they had seen improvements.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Statutory notifications had not always been submitted as required. Actions had not always been taken to ensure services improved for people. People had not always experienced improvements as a result of sharing their views.

A registered manager was in place. Spots checks were in place to check on the competency of staff and phone calls were made to check if people were happy when their care was first provided.

Derbyshire Care Services

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 over 20, 21, 22 and 30 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included two inspectors and one expert by experience who spoke with people on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all of the key information we held about the service. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

In addition, during our inspection spoke with eleven people and five relatives on the telephone. We also spoke with the registered manager, the nominated individual and the director. We spoke with the training manager and four care staff.

We looked at four people's care plans and reviewed other records relating to the care people received and how the agency was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Requires Improvement

Is the service safe?

Our findings

We looked at how the provider recruited and managed staff. The provider's recruitment policy stated they would obtain a minimum two references for people applying to work at the service; one of those from their current or previous employer. Records showed this policy had not been consistently followed for three out of the four staff recruitment records we checked. In addition, the provider is required to assure themselves of the reasons for any gaps in an applicant's employment history. We found unexplained gaps in the employment histories of two of the four staff recruitment files we checked. Staff told us they completed an application form and had their references checked before they started work. Other pre-employment checks, such as applicants identity and checks from the disclosure and barring service had been completed. Pre-employment checks help providers decide if staff are suitable to work with people using the service. The provider had not completed all recruitment checks in line with their own recruitment policy to assure themselves of the safety and suitability of staff appointed to work with people using the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments and care plans were not always reviewed or updated in a timely manner when people's care needs changed. For example, where a healthcare professional had advised a person required a different position in bed for the care of their pressure sore; updated guidance for staff on what was required was dated four months later. Not all reasonably practicable actions to reduce risks associated with pressure areas were taken in a timely manner.

Not all risks to people's safety associated with their health condition were assessed to help inform their related care and safety plans. Risk assessments were not in place for all areas of risk. This was because one person demonstrated some behaviour that could present challenges to care staff. We saw care staff had reported an incident where a person had demonstrated behaviour that was challenging towards them. Although records showed the situation had been reassessed this had not resulted in a written plan to show the control measures staff needed to follow to reduce the risk. Although staff reported related accidents and incidents to the office when they occurred this had not always led to clear guidance on how to reduce risks further.

In addition, risk assessments were not always complete. One person used equipment to help them mobilise. Their care plan stated an individual moving and handling assessment had been completed; this had been designed to identify risks in the environment such as a lack of space, and other risks such as whether the transfer involved any twisting and ways to reduce those risks. However, we found this had not always been fully completed. This meant not all steps had been taken to reduce risks as risk assessments were not always fully complete. This meant some risks may not have been assessed.

People felt care staff helped them to reduce any risks associated with their care on a day to day basis. For example one person told us, "If [care staff] see something they'll tell me; if they think they can help with my health, they do." Another person told us, "I talk a lot with one of the [care staff], about all sorts of things; part

of that is we think about what I need to do to reduce risks." All the people we spoke with told us care staff wore gloves and aprons as needed to help prevent and control infections. Care staff we spoke gave examples of how risks were identified so that steps could be taken to reduce risks. For example, one care staff member told us, "Assessors go round all the time and flag up any problems." Another care staff told us, "Equipment can only be used when our assessors have been out to assess the person using it." Records showed risks had been identified with regard to specific risks, such as any equipment used to help people to move.

Staff told us they had been trained in safeguarding people and knew what action to take should they have any concerns about a person's safety. For example, staff told us how they would recognise any suspected harm or abuse of a person. However, the training matrix showed not all care staff had undertaken training in safeguarding adults. The training matrix showed these care staff had been booked to attend this training during July 2017. We were shown training material, used to train staff in safeguarding. This was dated 2013. The Care Act 2014 introduced new categories of abuse; these were not contained within the training guidance we were given, although they were included in the provider's safeguarding policy. The registered manager could not provide assurance's staff were trained to be knowledgeable in all categories of abuse as these were not included in the training material we were told were used. Records showed where one allegation of abuse had been made; the registered manager had investigated this. However no safeguarding referral had been made to the local authority as required. Local authorities are the lead agency coordinating any response from allegations of abuse. There was a risk allegations of abuse would not be safely dealt with when they were not reported to the local authority. The provider had not taken all steps to reduce the risk of abuse and preventable harm to people using the service.

People told us they felt safe with their regular carers. One person told us, "I don't have any concerns with them." Another person told us they felt safe with their care staff because, "They are quite chatty; you get used to them." However two people told us they would feel safer if they had regular care staff. One person told us, "Some of [the care staff] are alright, some are not so; and I need to know who is coming and then I'd feel safer."

People told us they had not received any missed calls although some people were affected when their calls were late. Some, but not all people received a phone call to advise them care staff were running late. One person told us their call was scheduled between 9am and 10am. They said, "There's been the odd morning when they've arrived after 11am; from time to time it happens. I think no-one's coming and that they've forgotten me; sometimes someone rings but not always." When asked, another person told us, "I don't know what time [care staff] are timetabled to come; On Saturdays they're meant to come at 12:30, but sometimes they don't arrive until 2pm." They told us this happened more when they did not have their regular care staff. They added, "No one ever rings about anything, so no, they don't let me know when they're late." Another person told us they required assistance of carers to help with their evening meal. They said, "If they don't come at a set time our meal can be ruined; they're supposed to come at 6:30, it's often 7:15pm; we never know if we can risk putting the food in the oven." Delays in call times were not always communicated to people and some people were adversely affected by receiving delayed care.

Some people had regular care staff and told us they were happy with this arrangement. However five people told us their care was affected by not having regular carer staff. One person told us they would like to have regular carers as, "It makes such a difference; I can have a routine with them; if it's a stranger I can't do this." Another person told us their regular carer was off sick, they said, "I don't know who's coming in; I'd rather have usual carers because you get used to them." A third person told us, "I need to know who is coming; who is in my home." A further person told us of an incident where they were worried about their privacy as

the care staff did not know a sliding door opened easily onto a shared landing area. The person told us the care staff had closed the doors and, "One brushed against the door; I had to shout to shut the door; It shows how important it is to have regular carers; this one was new, they didn't know if was a sliding door."

People told us they were not introduced to new care staff before they provided people's care. One person told us, "[Care Staff] just turn up and introduce themselves. I just tell them where things are." Another person told us, "I never know who is coming; they just show up." A third person told us, "No-one even lets me know if someone is coming who is new. I like to know because I get apprehensive about who is coming, I get a bit worked up."

We discussed our findings with the registered manager. The registered manager told us some rotas were sent to families where this had been requested, and some families visited the office to collect one. However, the registered manager told us staff rotas were no longer sent out to people and so people would not know what staff would be scheduled to support them. Although there were sufficient staff to meet people's needs, staff were not always deployed in a way that helped people feel safe. This was because some people did not feel safe and experienced worry from not knowing who was coming to deliver their care and from the lack of regular care staff attending their calls.

Most people we spoke with managed their own medicines or had help from family members to do so. One person told us care staff gave them their medicines; they told us care staff put their tablets in little pots and passed these to them to take along with a drink. They said, "[Care staff] make sure I've taken all of them." They told us they were happy with how care staff provided this care. Staff were knowledgeable on managing and administering medicines. One staff member told us, "It's quite strict when it comes to medicines; we follow the procedure and have to do everything how we are trained to do so." We saw staff completed medicines administration record (MAR) charts to confirm they had given people's medicines as prescribed. We saw these were returned to the office and checked for any errors. Any medicines errors were identified and actions taken to reduce the error reoccurring. For example, we saw a competency assessment had been completed on staff when a medicines error had occurred. The provider had taken steps to reduce risks to people associated with medicines.

Requires Improvement

Is the service effective?

Our findings

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

Records showed people's capacity to consent to their care had been considered in their care plans, however this had not been reflected in a mental capacity assessment. Where a person was considered to lack the capacity to consent to their care, any best interest's decisions taken, for example, for them to receive personal care in their best interests had also not been recorded. People told us staff asked them for their consent to care before it was provided. For example, one family member told us, [Care staff] always ask [my relative] if they can begin doing something first." When we spoke with staff, although they were clear on obtaining consent from people before they provided care, their knowledge on how they would do this if the person lacked capacity to consent varied. In addition, the training matrix showed not all staff had been trained in this area. As there were no best interests' decisions recorded in people's care plans for when they lacked capacity, the registered manager could not provide assurances staff always provided care in line with MCA.

Staff told us they attended training, although some staff were unsure if they had completed all relevant training, for example in the MCA. Records showed staff had not always received training identified by the provider as required for their job role. For example, in the MCA, fire safety, health and safety and tissue viability. Although staff felt the training they received was good, records did not show all staff were trained in the areas identified by the provider as required.

One care staff member told us they had regular training, they said, "The skills for the job change all the time, especially for medicines and moving and handling." They went on to tell us about new equipment they had been trained to use to help people to move safely when required. They said, "The moving and handling training is all practical." The staff training room contained relevant equipment for staff to practise safe moving and handing. The assessor with responsibility for training care staff told us care staff were supported to complete the Care Certificate. The Care Certificate aims to ensure care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care.

People and their families told us they felt staff knew how to care for them. One family member told us their relative was assisted to move by two carers by use of a hoist. They told us, "I'd say they do this very well." Another relative told us, "When [care staff] wash [my relative] they support [my relative's] body properly." A third relative told us, "[Care staff] seem to know what they're doing; they treat [my relative] very well."

People had mixed experiences when care staff had supported them to access other healthcare services when required. One person told us, "[My regular carer] has rung the GP and asked them to come and see

me." Another person told us, "When I first came out of hospital [care staff] did [help]; they would ring up my GP for instance; Now I'm doing it more myself." However two people told us they had not been supported effectively to access the healthcare they needed. For one person care could not be arranged to take them to their GP appointment, and another person told us the care staff did not help them obtain advice from their GP in a timely manner. Records showed the service had contacted other healthcare professionals, such as occupational therapists when required with any concerns they had identified. The service helped people to maintain good health as they identified when access to other healthcare was appropriate; although some people felt this had not always been effectively organised.

Staff told us they felt supported by the registered manager. One staff member said, "If we have any problems we can tell [the registered manager] and they will sort it out." They also told us they had supervision meetings and feedback on their care practice from managers, which they found useful. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. Records showed staff practice was observed when required to ensure staff competency. Related feedback was given to staff on where they had done well and any areas that required improvement.

People who received care with their meals and drinks had sufficient to eat and drink. One person told us, "After breakfast [care staff] make a sandwich and cake and a flask of tea for lunch when they've gone. At dinner they reheat a microwave meal; if I want anything at night they do that." The person told us they chose what they wanted to eat and drink and were happy how care staff prepared their meals. Another person told us, "[Care staff] put something in the microwave; they'll say what is in the freezer and I'll say what I want." Another person told us care staff made sure they had a good breakfast as they were diabetic. All people we spoke with told us care staff made sure they had access to drinks throughout the day. One person told us, "I have a big jug; they fill it with water and change it at lunchtime." Another person told us care staff always made them a cup of tea before they left. People received care so that they had sufficient food and drink that met their preferences and needs.

Good

Is the service caring?

Our findings

The provider's customer survey had identified most people felt staff were friendly and respected their privacy and dignity. From the people we spoke with, most people told us staff were caring. One person told us, "[Care staff] are lovely, very friendly; we chat and laugh all the time." Another person told us, "[Care staff] are very caring; they shower me in the morning and sometimes help me wash my hair; they talk all the time to me."

People told us staff were considerate to their home. One person told us, "If I want anything, [care staff] do it; my regular morning one picks things up from the floor and does things without being asked." They added, "[Care staff] never take liberties; they always ask if they can use my toilet, things like that." Another person said, "[Care staff] make sure I am alright; they make me a cup of tea before they go and one for my [relative]; they are so kind." People received care from staff who were caring and considerate.

People told us where care staff had promoted their independence. One person told us care staff only reminded them to take their medicines now. Previously, when the person had just come out of hospital care staff had given the person all their medicines. They told us, "I'm definitely happy with this because I'm a lot better now." Care staff we spoke with provided examples of how they encouraged people's independence. One said, "I ask people if they want to come and help make a sandwich." They went on to say one person wanted to get more mobile after their surgical operation and they used a perching stool so they could help in the kitchen. Care staff promoted people's independence.

People told us care staff respected their privacy and helped to promote their dignity. One person told us, "[Care staff] cover me with a towel; they are very good like that." Another person told us, "[Care staff] make sure the blinds are down." Staff provided examples of how they worked to respect people's privacy and promote their dignity. One staff member told us their training covered how to respect people's privacy and dignity. Care was provided to promote, people's dignity and privacy.

People told us they were involved in agreeing a care plan in place at the start of their care. One person said, "At the beginning [staff] came up from the office, my [family member] was there, they asked us everything and we put it all together." Another person told us their care plan was in front of their folder; they told us they felt involved in the process, they said, "I make the decisions." A third person told us, "I was very involved because it was my answers." People and when appropriate, their families, had been involved in planning people's care.

Requires Improvement

Is the service responsive?

Our findings

Some people did not feel they contributed to reviews of their care. One person told us when they had first received care they were not well enough to contribute and their family members had contributed to their care plan; they told us they were now better. They said, "My care plan should be revised to reflect this situation; [previously] I wasn't in a position to contribute, this time I'm completely capable of doing it on my own." Another person told us, "The last review was about three years ago; I feel a bit forgotten." A third person told us, "It seems a while since anyone has come here [to review the care plan] again." One relative we spoke with told us there had been a review of their relative's care and they were involved. However three other relatives told us the related person's care plan had not been reviewed. One said, "Nobody's been out to review it; I'm not sure it's ever been reviewed." Another relative commented the care plan lacked details, they said, "I think it just says personal care, nothing else, no detail."

Records showed reviews of people's care varied. For some people, reviews had been recently held and included the person and their family members, if this was their wish. However other people's care plans and risk assessments did not show reviews had been held. For example, one person had an individual manual handling plan dated significantly before the provider had been registered at its current location; there were no reviews of this care plan recorded. At some point this person's needs had changed and they required the use of a ceiling track hoist to assist them with transfers. Their care plan contained a 'temporary moving and handling support plan' that provided instruction to use the ceiling track hoist; this was not dated so we could not tell when this person's needs had changed. In addition, the care plan contained contradictory information; staff were instructed to use both a stand aid and a ceiling track hoist when providing care for this person to transfer to the commode. The care plan and risk assessments had not been comprehensively reviewed to ensure care was consistent and responsive to meet people's needs.

People told us most care staff respected their known views and preferences; however some people commented that this was less so when their care was not provided by their regular care staff. One person told us, "Some days I'm not up to having a shower; [care staff] sit and talk to me instead; they know this helps me." Another person said, "My regular carer chats with me; when they take their time it's very good; I think they know my likes now." A third person said, "Some [care staff] that come are alright, some others I don't know at all." They went on to tell us not all care staff knew their preferences and said it was, "Because they don't know me, how can they?" People's views and preferences were respected by staff that knew them; however this was not always the case when people's care was provided by staff not known to people.

The registered manager told us they were able to meet people's cultural views and preferences. For example, they told us and discussions with staff confirmed, some staff were fluent in languages other than English and used these skills when people preferred care from care staff who spoke their own language. People's cultural views and preferences were known and respected.

People told us they had been able to contact the office to raise concerns or make a complaint. One person told us, "I've just rung and said I'm not happy; they've apologised and said it would be dealt with." They told us they were happy with the actions subsequently taken by the registered manager. Another person told us,

"I was told that I could always phone the office; If I'm not satisfied with any situation I would ring." They added they had done this before and said, "They listen to me." Other people told us they were satisfied with the actions taken by the service if they had raised any concerns. One person said, "I complained about a carer and I told them to stop them from coming; they haven't been since; they were efficient and listened."

People received information on how to make a complaint if they needed to. There was a policy and procedure in place for the handling and investigation of any complaints received. Records showed 31 complaints had been received in the three months previous to our inspection. Records showed these had been reviewed and actions taken to respond to people. Out of the 31 complaints, seven related to people not wanting specific carers, five related to not having regular carers and seven were unhappy with their call times. However, there were no actions identified on responses to these trends. During our inspection, people had commented on not having regular care staff. People were able to complain or make feedback on the care they received. However, whilst people's concerns were responded to individually, there was no evidence to show how the service were looking to resolve wider issues.

Requires Improvement

Is the service well-led?

Our findings

The provider was not able to provide assurances that records of people's care were accurately maintained and kept up to date and complete. This was because risk assessments in people's care plans were either not dated or were out of date. For example, one person's risk assessment for their moving and handling and medicines had been reviewed significantly before the provider had registered at its current location. The provider's policy states reviews of people's care should be completed on an annual basis as a minimum standard. We discussed records with the registered manager. They told us people's care plan records were not audited. Therefore there was no system or process in place to effectively check on the quality and safety of care plans and risk assessments. The registered manager told us they would introduce audits of people's care plans and risk assessment paperwork. Records of people's care were not always up to date and complete.

In addition management systems to check on the quality and safety of staff recruitment had not identified recruitment practices were not in line with the provider's own policy for the employment of persons involved in the provision of a regulated activity. Nor had systems been operated effectively to ensure staff training had been completed in the areas identified by the provider as required; or demonstrated dates for this training had been arranged.

The service is required to have a registered manager and a registered manager was in place at the time of this inspection. The registered manager and provider are required to send statutory notifications to CQC when required. Notifications are changes, events or incidents that providers must tell us about. At the inspection, the registered manager was not always clear about their responsibilities to notify the CQC of the incidents that the provider was required by law to tell us about; such as any allegations and incidents. Whilst we had received some statutory notifications, we had not received statutory notifications required for all events and incidents when they happened at the service. Some statutory notifications sent to us had been completed incorrectly. We discussed this with the registered manager who agreed to ensure statutory notifications would be completed correctly and submitted when required.

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

People had been asked for their views about the quality of the service; however people were not always certain actions had been taken in response to their comments. One person told us, "Any change isn't noticeable; you need to do it personally, a bit of paper doesn't get listened to. What I want is to know who is coming to my home." Another person told us, "They send out a questionnaire every now and again; there is a bit at the end for your comments; I don't know if anything is ever done though."

We saw the customer survey had been analysed and comments from people requesting the same care staff had been identified. The comments included, "I've repeatedly asked for the same carer and been assured of it but it doesn't happen," and, "My [relative] gets concerned about new people calling without ever seeing them before. Also newer they are, less familiar they are with [their] requirements." Although the provider had

stated an action plan would address areas for improvement, people we spoke with had not yet experienced an improvement in the continuity of their care staff. Neither had they received any information on what actions the provider planned to take to improve their care. People's views were gathered, however not all people had seen improvements to the issues they had raised regarding how the service operated.

In addition, not all actions to ensure the quality and safety of care to people had been taken when complaints had been made. We found one person had complained of a late lunch call over a weekend. It was important for this person to have regular lunch calls as they were diabetic. The complaint had been investigated and stated the person's next of kin would be informed of any future delays. We saw the service had a 'time critical list' for people who needed to receive their care on time. This person had not been added to this list. We discussed this with the registered manager who confirmed they would be added; this was four weeks after the original missed call. Not all actions were taken to improve services.

Some people told us they had phone calls from the office to check they were satisfied with their care. One person told us, "I think they phone up to say is everything alright." One family member told us, "Now and again they ring and ask if everything is alright." Records showed phone calls were made to new customers for a period of time to help identify any issues with their care.

One care staff member told us, "We have spot checks; we're not told when [managers] are coming. They check medicines, moving and handling, our uniform and records." Records confirmed these checks were in place and feedback was provided to staff where any improvements were identified as needed. Systems were in place to check on the quality of care provided by staff.

The registered manager was supported by administrative staff as well as staff that assessed people's needs and care staff who provided people's care. None of the people and families we spoke with knew who the registered manager was. They told us they would call the office if they needed any help or information. They told us they found office staff helpful and approachable. One person told us, "The office staff are very good." Staff we spoke with told us they felt able to talk directly with a director as well as the registered manager; to raise feedback or any concerns about people's care. One staff member told us, "I can talk to [director]; she's there to talk; the [registered manager] is there when she can; she tries her best." Another staff member told us when talking about the registered manager, "There are definitely no problems speaking with [registered manager]." Although people and families did not know the registered manager they felt able to contact the office staff; staff we spoke found the registered manager and director approachable.

Staff we spoke with told us they enjoyed their role. One staff member told us, "I enjoy working here." Another staff member we spoke to told us, "I'd be happy to recommend working here; staff are happy here." Records showed staff meetings were held and provided staff with opportunities to share views about the service and raise issues with managers. We saw issues raised had been listed and individual people had been given responsibility to resolve them. Timescales for this were not recorded, however staff we spoke with told us managers did act on any concerns raised. One care staff member told us, "If we have any problems we can tell [managers] and they sort it out." These meetings provided opportunities for staff to contribute. Staff had opportunities to contribute to share their views and contribute to developments and improvement in 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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes to assess, monitor and improve the quality and safety of the services provided. In addition, records were not always accurate, up to date or complete. Regulation 17

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not undertaken thorough recruitment checks to ensure staff were safe to work with the people who used the service. Regulation 19