Care-Away Limited

Care Support Newham Branch

Inspection report

1a Claughton Road
Plaistow
London
E13 9PN

Tel: 02084712065

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12, 13 and 14 December 2017. The provider was given 48 hours' notice as they provide a care service to people in their own homes; we needed to be sure someone would be available to us.

Care Support Newham Branch is a domiciliary care agency. It provides personal care to people living in their own homes. Most of the people receiving a service are older adults. At the time of our inspection they were providing care to approximately 140 people.

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

At the last inspection in November 2016 we issued the provider with three warning notices which required them to address breaches of our regulations regarding safe care and treatment, person centred care and good governance. The provider had taken steps to address our concerns about governance and person-centred care, but issues with the safety of the service remained.

Risks to people were identified through the care plan assessment and review process. However, the measures in place to mitigate risk lacked detail and were not always clear.

People were supported to take medicines by their care workers. However, the systems in place did not ensure this was managed in a safe way as there were discrepancies between the information held in care files and medicines records. Medicines records were not always complete.

The provider had completed work to improve the quality and detail in care plans. However, the level of information varied and not all plans contained sufficient detail to ensure people received personalised care. The provider demonstrated they understood the level of detail required. They submitted updated plans and an action plan to ensure all care plans contained the required level of detail.

The provider had not submitted all the notifications they were required to submit to us by law.

The quality assurance and improvement systems were not effective in fully addressing the concerns identified at the last inspection. However, the registered manager responded positively to our feedback and submitted a creditable and realistic action plan following the inspection.

People told us they were visited by regular care staff. Records showed care was not always delivered on time and the provider recognised they faced challenges with the number of staff employed at specific times of the year. Staff were recruited in a way that ensured they were suitable to work in a care setting.

People felt safe with their care workers. Staff had a good understanding of safeguarding adults from avoidable harm and abuse. The provider had systems in place that ensured action was taken in response to incidents and allegations of abuse.

People were protected by the prevention and control of infection and staff told us they were well supplied with personal protective equipment.

People's abilities and preferences in relation to their care were assessed through a comprehensive needs assessment process which was reviewed regularly. Care plans contained information about people's religious beliefs, cultural background and personal history. The provider did not explore the impact sexual orientation may have on people's experience of care. We have made a recommendation about ensuring the service is following best practice for people who identify as lesbian, gay, bisexual and transgender.

People told us care workers supported them to prepare and eat their meals. Care plans contained details of people's dietary preferences. Where people were at risk of not eating enough to maintain sufficient nutritional intake care workers maintained records of what people ate to assist healthcare professionals in providing support.

People told us care workers supported them when they were unwell. Care plans contained information about people's healthcare diagnosis and the contact details of relevant healthcare professionals were available to staff.

People consented to their care and told us their care workers offered them choices. Where people lacked capacity to consent to their care the provider followed the principles of the Mental Capacity Act 2005.

People told us their care workers were kind and treated them with compassion in a way that upheld their dignity. People's preferences with regard to the gender of their care worker were respected.

People knew how to make complaints if they needed to. Records showed the provider responded to complaints in line with their policy and procedure.

The provider's approach to end of life care was task focussed. However, they were in the process of training and developing their approach to providing end of life care.

People and staff spoke highly of the registered manager. The registered manager told us they valued their staff and thought they demonstrated appropriate values to work in a care setting.

The registered manager worked with other local organisations and managers from within their own organisation to ensure the service was continuously developing.

We identified two breaches of regulations regarding safe care and treatment and notifications. 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 overall rating for the service is Requires Improvement. This is the second consecutive time the service has been rated Requires Improvement.

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. The service had made some improvements in risk assessments, but measures in place to mitigate risks still lacked detail in key areas.

The service did not have effective systems to ensure people received medicines in a safe way.

People felt safe with their care workers. Care workers were knowledgeable about safeguarding adults and the provider took appropriate action in response to allegations of abuse and incidents.

Staff were recruited in a way that ensured they were suitable to work in a care setting. Records showed people did not always receive their visits on time.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. People were involved in their needs assessments and care was planned in line with current guidance.

Staff received the training and support they needed to perform their roles.

People were supported to eat and drink in line with their needs and preferences.

The service worked with other organisations to ensure that people's healthcare needs were met.

The service worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People told us their care workers were kind and treated them with compassion and respect.

The service asked people for their views and preferences and acted upon the views expressed.

Care plans contained details of people's religious beliefs, cultural background and personal histories to help care workers provide holistic support. The provider did not yet explore if sexual orientation had an impact on people's experience of care.

Is the service responsive?

Requires Improvement

The service was not always effective. The level of detail and personalisation in care plans remained varied.

The provider reviewed people's care regularly and updated care plans when needed.

People knew how to complain and records showed the provider adhered to their complaints procedure.

The provider was developing its approach to supporting people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well-led. The quality assurance systems in place had not fully identified or addressed issues with the quality and safety of the service identified during the inspection.

The provider had not notified us of events as required by them by law.

People and staff spoke highly of the registered manager and felt they were involved in providing feedback about the service.

There was a clear vision and set of values that were known and adhered to by staff.

The provider had a plan for the development and sustainability of the service.

The provider sought and followed best practice guidance and support.

Care Support Newham Branch

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.

Care Support Newham Branch was last inspected in November 2016 when we issued three warning notices regarding safe care and treatment, person centred care and good governance. The provider had made some progress in addressing these concerns but issues with the quality and the safety of the service remained.

The inspection took place on 12, 13 and 14 December 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a community based service and the manager is often out of the office supporting staff. We needed to be sure they would be in.

The inspection was carried out by two inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience had experience of using or caring for someone who used a domiciliary care 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 reviewed this information as well as other information we held about the service in the form of notifications they had submitted to us. A notification is information that providers are required to submit to us by law. We sought feedback from the commissioning local authority and local Healthwatch.

During the inspection we spoke with 11 people who used the service and one relative. We spoke with 12 staff members including the registered manager, the nominated individual, the training manager, two coordinators, and six care workers. We reviewed ten care files including needs assessments, care plans, risk

assessments and records of care delivered. We reviewed twenty staff files including recruitment, training and supervision records. We also reviewed various other documents and policies including incident reports, quality audits, meeting minutes and strategy documents relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because although risks had been identified by the provider, there was insufficient information to inform care workers how to mitigate these risks. At this inspection we found the provider had made some progress in ensuring care workers had better information available to them, but risk assessments remained insufficient.

The provider had a system where risks were identified as part of the initial assessment and again during reviews. There was a separate plan to address risks identified as having a medium or high impact on the person. However, the information about how to address risks remained insufficient. For example, in the moving and handling risk assessments reviewed there was no information about the hoist in use, how to support the person to use the equipment safely and no reference to guidelines written by a suitably qualified moving and handling assessor.

The information for care workers about how to mitigate risks associated with behaviour which could challenge staff and the service was insufficient. For example, one person was identified as displaying behaviours which could pose a risk. Their risk assessment stated, "Care worker should be informed about [person's] mental health condition, any trigger points, and should know how to handle the situation." There was no guidance to inform care workers how to "handle the situation."

Risk assessments in relation to specific health conditions that people lived with were generic and did not contain specific details for care workers to follow. For example, risk assessments in place for people with epilepsy were identical and reflected the generic information sheets about epilepsy that were available to care workers. They stated, "[Person] has epilepsy. They should be supervised at all times. Care workers should be informed about the condition and what symptoms to look out for and how to manage any convulsions in an emergency. Keep record of number of convulsions." There was no information about each person's individual triggers for seizures, how their seizures manifested or what type of seizure they had.

Some people had diabetes and their care files contained a fact sheet about foods for people with diabetes, but the risk assessments in place to support care workers to identify and respond to diabetes related emergencies were insufficient. For example, one person's diabetes risk assessment stated, "Ensure care workers have had training for diabetes. Ensure [person] maintains a good diet and takes her medication correctly." There was no information about how the person may present in a diabetes related health emergency or how care workers should respond. This meant people remained at risk of unsafe care and treatment as staff did not have sufficient information about how to support people in a safe way.

People told us care workers supported them to take their medicines. One person said, "They help me to take my medicines." Another person told us, "I take my medicines myself but the care worker always checks which is good in case I forget." Care files contained a list of medicines that people had been prescribed and information about the purpose and potential side effects of these medicines.

However, there was not enough information to inform care workers how to support people to take their medicines in a safe way. For example, one person's care plan stated, "I need assistance with administering my medication." There was no description of what this assistance consisted of. Another person's care plan stated, "I require the care workers to administer my medication." There was no guidance to inform staff how to do this. A third care plan stated, "I would require the care worker to prompt my medication" with no further instructions about how to do this.

We reviewed the medicine administration records (MAR) completed by care workers. We found discrepancies between the medicines listed on the MAR and the medicines listed in the care plans. One person's MAR contained three medicines that were not on the medicines care plan, and the dose instructions for a further two medicines were different on the MAR compared to the care plan. A second person's MAR contained five medicines that were not included in their care plan. A third person's records of care showed staff were administering prescribed eye drops which were not included on the MAR or care plan. This meant people were at risk of not receiving their medicines in a safe way as staff did not have clear information about what support people required to take their medicines.

Records showed the MAR charts were collected regularly and audited by coordinators. The audits identified where there were gaps in record keeping and noted that care workers had been spoken to about this. However, it was not clear whether the coordinators had checked whether this was a gap in recording or a missed medicine. For example, one person's MAR showed 19 occasions in August 2017 where medicines had not been recorded as administered. The auditor had noted, "Care worker advised to put initials if they make any corrections." In September and October there was a reduction in missing records to three.

We discussed our concerns about the quality of risk assessments and medicines records with the registered manager. In response they submitted updated risk assessments and medicines plans for two people. Although these were improved they still lacked detail in key areas. For example, one person's diabetes risk assessment stated, "Ensure [person] maintains a good diet and takes her medication correctly. Care worker to always look at the care plan." This remained insufficient to appropriately mitigate the risks. The moving and handling risk assessment now contained information about slings, but it was still not clear how to support the person safely as the risk assessment stated, "Care workers to use the white sling for the upper part of the body and the green sling for the lower part of the body and remove the slings whilst [person] is seated in her chair." This meant people remained at risk of unsafe care and treatment.

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

People told us they felt safe with their care workers. One person said, "I feel safe with them." Another person said, "I see the same two people all the time which is very reassuring." A third person told us, "I trust them [care workers]." Care workers were confident in the action they would take to respond to allegations of abuse. One care worker said, "I would write it down and report it. If the office didn't do anything I would keep on at them until I know something is being done. If there is something going on I don't just leave it there. I keep following it up until I know something is done."

The provider had a clear policy on safeguarding adults, which included details on how to escalate concerns to the local safeguarding team, as well as internal whistleblowing processes. Records showed the provider identified and escalated concerns about people being abused appropriately and took action to ensure people's safety. This meant people were safeguarded from abuse.

We reviewed incident forms within the service. These showed care workers escalated concerns and

incidents to the office based staff in line with the provider's policy. However, actions taken to ensure incidents were not repeated were not always clearly completed. For example, one person's mobility and falls care plans had not been updated following a fall. Records showed that individual care workers were spoken to about missed visits, or if injuries were reported by care workers appropriate medical attention was sought. However, the audit showed that none of the incidents were deemed to warrant an action plan to address concerns and incidents were not discussed in any of the various team meetings that took place. This meant it was not clear that the provider took action to ensure lessons were learnt from incidents in order to improve the service received by people.

People and staff gave us mixed feedback about the staffing levels at the service. Although most people told us they had regular care workers who came on time, others told us they had problems with the consistency of the service. A relative told us, "I don't think they have enough staff. If one is off sick they have a job to find someone else." All the care workers we spoke with told us they were asked to provide cover for absent colleagues at least once a week. One care worker explained, "I think they have enough [staff] but sometimes many carers take holidays or call in sick at the same time, so unexpectedly they will ask you to go in and cover."

We discussed this with the registered manager who advised the service struggled with staffing numbers at particular times of the year. This was an issue during religious festivals as many of the staff team would request to take leave at the same time. As all the care workers were employed on a 'zero hours' contract the service was not able to manage or prioritise leave at these times of year. The registered manager told us, and records confirmed, they were continually recruiting additional care workers and were considering introducing contracts which would limit the impact of many staff taking holidays at the same time.

Records showed the service continued to operate a robust recruitment system. The provider carried out appropriate checks on staff to ensure they were suitable to work in a care setting. This included checking their right to work in the UK as well as whether or not they had a criminal record. The provider collected employment and character references to ensure staff were of a suitable character to work with people in their own homes. The registered manager told us they placed a high value on the motivation and values of the care workers they recruited. This was reflected in the interview questions which explored the values of applicants before they started to work in the service. This meant the service had ensured they had recruited suitable staff to support people.

The provider continued to use their electronic call monitoring (ECM) system to monitor care worker attendance at care visits. We reviewed the electronic call monitoring data of nine people who used the service and 11 care workers. These records showed that where people required two care workers they received care from two workers who arrived and left together. The records showed people received the amount of care scheduled. However, an analysis of the punctuality of care workers did not match the feedback people gave us. People told us their care workers were usually on time, and only occasionally late. This did not match the ECM data which showed punctuality of care workers varied from the scheduled visits significantly. For example, in a two week period one person was scheduled to receive 60 calls, of these only 12 were within 15 minutes of the scheduled time and 17 were over an hour outside the schedule. Another person had 27 visits scheduled and only 18 of these took place within 15 minutes of the schedule. For a third person only 13 out of 36 calls were within 15 minutes of the schedule.

The registered manager told us they used live monitoring to ensure care visits were completed. The system triggered an alert if care workers did not log in and care workers were contacted to establish their whereabouts. Records showed the provider used the system to ensure people received their visits. However, the discrepancies between scheduled and actual visit times showed the schedules were not being adhered

to. The registered manager told us the commissioning referrals did not always reflect people's preferences and adjustments were made to people's schedules after they had started to receive a service.

Staff told us they were well supplied with gloves and other personal protective equipment required to ensure people were protected by the prevention and control of infection. People told us staff wore gloves and other protective equipment while supporting them with personal care tasks. The provider had different formats of care plan in use in the service, and the newer versions all contained prompts and reminders for care staff regarding appropriate hand hygiene and infection control techniques. Care worker meeting records showed that staff were reminded about good practice in terms of infection control on a regular basis. This meant people were protected by the prevention and control of infection.

Good

Is the service effective?

Our findings

People told us they were involved in their needs assessments and the creation of their care plans. One person said, "They came over and did a survey of what I need and what I don't need." A second person said, "I was involved in writing my care plan." A relative told us they were involved in the assessment process. They told us, "We were involved [in the assessment]. The care plan does reflect her needs at present."

The care files reviewed showed the provider had developed their approach to completing needs assessments and care plans, and two formats were seen within care files. The newer assessments and care plans encouraged a person centred approach by focussing on what was important to people and what they wished to change through support.

The assessments emphasised people's choice and control over the support they received and reflected people's character through the assessment process. For example, people's independence was noted as were their strengths in maintaining this where possible. The assessment prompted the assessor to consider people's religious beliefs and cultural background to ensure care was planned in a way that reflected people's preferences and focussed on the outcomes of care interventions. For example, ensuring people maintained current levels of health and mobility. This meant people's needs were assessed and care designed in line with current legislation, standards and guidance.

People told us they thought staff were good at their jobs and had received the training they needed to perform their roles. One person said, "They [care workers] are good at what they do." Another person said, "They know what they are doing." The provider had continued to provide staff with a comprehensive induction training programme which covered the criteria of the Care Certificate. The Care Certificate is a nationally recognised qualification that ensures care staff have the foundation knowledge required to work in a care setting.

The provider continued to provide staff with regular updates on key training courses in areas relevant to their roles and records showed staff were up to date with their training. One care worker said, "The training is very good. Our trainer at the moment is brilliant. You can ask her everything and she'll find out for you." The training manager explained to us how they sought best practice guidance and worked with Skills for Care to ensure their staff had the knowledge and skills required for their role. Skills for Care is a strategic body for workforce development in adult social care in England.

Staff told us, and records confirmed they received supervision in line with the provider's policy of at least quarterly contact with their line managers. A care worker explained the process, they said, "They come out and do a visit and check we're doing everything we're meant to be doing. Then we have a meeting in the office as well. You don't have to wait for supervision if you've got an issue though. I was worried about something and I just called up the office and they sorted it." The training and supervision provided to staff ensured they had the knowledge and skills to meet people's needs.

People told us care workers supported them to eat and drink in line with their choices and preferences. One

person said, "They give me a choice with my meals." Another person said, "My care worker helps me do my food." Care workers told us they helped people prepare meals and supported them to eat where this was required. Where the service was commissioned to support people with their meals their preferences were clearly recorded in their care plan with instructions for care workers if people required special assistance to eat. We noted that one person's care plan contained conflicting information about the consistency of food it was safe for them to eat. The provider took immediate action to clarify the situation and updated the care plan to reflect what the person could eat safely. When people were at risk of not eating enough care workers recorded the detail of how much people ate, to facilitate health professionals who were monitoring people's dietary intake. This meant the service ensured people were supported to eat and drink enough to maintain a balanced diet.

Care plans contained contact details for other professionals involved in people's care. This included district nurses, GPs, social workers, dieticians and speech and language therapists where relevant. Where specialist advice and support was in place the details were included within the care file. For example, a speech and language therapist had written a report recommending specific support for one person's eating and drinking. However, this specialist advice had not always been incorporated into the care plan, although it was referred to. This meant care workers had to find the information within the file, rather than it being clear from the relevant section of the care plan what they had to do. This was discussed with the registered manager and updated care plans submitted to us included the details of professional advice within the main body of the care plan. This meant the service worked with other organisations to ensure people received effective care.

People told us care workers supported them with their healthcare needs. One person said, "Once I didn't feel well and she rung her office and they said ring the ambulance and she waited with me until the ambulance came." Another person told us their care worker supported them to attend regular healthcare appointments. A relative told us, "They called one of us to say my mum wasn't well, and the care worker stayed with her." Care plans contained details of people's healthcare diagnosis and contact details of medical professionals. Care workers were confident in the steps they would take if someone appeared unwell while they were providing care. They told us they would contact the office and seek medical attention if needed. We noted that while care plans listed people's diagnoses, they did not always describe how these affected people, to support care workers to identify if someone was more unwell than usual during a care visit. In response to this feedback the registered manager submitted updated care plans which contained a greater level of detail about people's usual presentation. This meant the service supported people to have access to healthcare services and receive on-going healthcare as appropriate.

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 interest 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 application procedures for this in the community are via the Court of Protection. We checked whether the provider was working within the principles of the MCA.

Where people had capacity to consent to their care this was clearly recorded as they had signed consent forms within the files. Some people had legally appointed decision makers, and the service had copies of these legal authorisations. However, these showed that people had a legally appointed decision maker for decisions relating to their finances and property, not their health and welfare. This meant these people

could not consent to care on behalf of the person. It was clear from the care plans that families had been involved in writing and designing care in a way that reflected the best interests' approach of the MCA.

People told us they were offered choices by their care workers. One person said, "They let me choose what clothes to wear. They leave it up to me how much help I want such as when having a bath, they always ask what I want them to help with even though they do it often." Care workers told us they offered people choices. One care worker said, "Most of the people I support can make their own choices. If they can't I'll check things with their family to make sure." Another care worker said, "People still make their own choices, I still treat them equally."

Good

Is the service caring?

Our findings

People told us they liked their care workers and they displayed a caring attitude towards them. One person said, "They're helpful." Another person said, "They're very kind." A third person told us they thought their care worker genuinely cared for them. Another person told us, "She takes care. She talks to me and asks me. They're all very pleasant and I feel comfortable with them." People told us they had been able to build up their relationships as they usually had the same care workers visit them on a regular basis.

Care workers told us they got to know about people's pasts by talking to them and their family members. They also told us they received information from the care plan which helped them get to know about people they supported. One care worker told us, "The family might call the person while you're there. After they've finished you have a chat, ask them who it was. You can see from their faces they like to talk about their families." Another care worker said, "I do like to chat. I don't just go in and do the job and leave. I always have a good chat to find out about them. I don't pry but I do like to get to know them, about what they like and don't like. That level of detail goes into the care plan."

Care plans contained information about people's communication preferences as well as an outline of people's life story. This included information about where people had grown up, where they had worked and things that interested them. The provider also collected information about people's religious beliefs and cultural background and captured whether this had an impact on people's support preferences. One care worker explained, "In this area we support people with a lot of different religious beliefs. Some of them like us to do things in a particular way. There's one lady and when I work with her, her daughter asks me to cover my shoes." Care plans showed that people were asked if they had preferences regarding the gender of their care workers. Records of visits completed showed the provider respected these preferences. One person commented, "It's brilliant having a male carer." This meant people were involved in decisions about their care.

People told us they felt they were treated with dignity by care workers. One person explained, "They [care workers] are polite and compassionate. They respect my privacy." Another person said, "Having the same carer helps me retain my dignity. They are very respectful when helping me bathe." Care workers described how they supported people to maintain their dignity. One care worker said, "I'll ask if I can do various tasks. I'll explain what I have to do. I make sure the door is closed, everything like this." The provider had signed up to the social care commitment and information about dignity was on display in the training room. The Care Commitment is a Department of Health initiative to facilitate social care providers promise to ensure people receive high quality services. This meant people were supported to maintain their dignity.

Care plans did not contain information about people's sexual orientation or identity. We asked care staff if they supported anyone who identified as lesbian, gay, bisexual or transgender (LGBT). Staff responses were mixed and not all of them demonstrated an understanding of the impact sexual orientation may have on people's experience of care. For example, one care worker said, "No [no one identifies as LGBT] because my regular clients they have got kids and so on. So no, they have kids and everything so they are not lesbian." Another care worker said, "I don't [support anyone who identifies as LGBT]. That has nothing to do with the

care plan." However, a third care worker demonstrated a better understanding of the impact sexual orientation can have on the experience of care. They said, "One person I work with is gay. He told us and is very open about it. It's captured in the records. As far as I know it doesn't affect his experience of care. I wouldn't treat anyone any differently. He's very open." As the provider did not explore sexual orientation with people as part of the assessment, there was a risk that people did not feel safe to disclose this information and this could affect their experience of care.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring homecare services are accessible to people who identify as lesbian, gay, bisexual and transgender.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in November 2016 we issued a warning notice for a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not personalised and people's views were not used to inform the delivery of care. The provider had made significant progress in addressing these concerns, although some inconsistencies in the level of detail in care plans remained.

People and relatives told us they were involved in planning and reviewing their care. One person told us, "We have a review once every couple of months." Another person said, "They do ask me [for feedback about my care]. Every three months." Records confirmed care plans were reviewed regularly and people and their relatives were asked for feedback on how they felt their care was going.

After our last inspection in November 2016 the provider had completed a work plan where all care plans were reviewed and updated. In addition, they had introduced new formats for care plans which included more prompts to ensure care plans were written in a personalised way. The level of detail and personalisation within care plans remained varied. Some plans contained a high level of detail, enabling any staff member who read the plan to be able to provide support in line with the person's needs and preferences. For example, one care plan contained details of how to greet the person, the specific tasks to be completed and which aspects the person could do independently and which aspects the care workers were required to support with. The plan included details of the location of the equipment required, water temperatures preferred and products used.

However, other plans had less detail. For example, one plan described how to greet the person and their preferred communication but then the care plan just listed the tasks to be completed without any details of the person's preferences or abilities in relation to these tasks. The care plan stated, "My personal care includes being given a strip wash, having cream applied to my body." It continued with a list of other tasks, but as there were no details about how to deliver the care in a way that reflected their preferences there was a risk that the person did not receive care in a personalised way.

This was discussed with the registered manager who submitted copies of amended care plans which demonstrated they had understood the level of detail required in care plans. Records showed the registered manager met regularly with staff who completed care plans and reviews. We reviewed these meeting minutes which showed the registered manager was clear with staff about the expectation on the quality and content of care documentation.

The provider had a clear policy on complaints which included details of expected timescales for response and how to escalate concerns if complainants were not happy with the outcome. People told us they knew how to raise concerns and were confident to do so. One person said, "I would just phone them up." Another person said, "I would phone the office up. I've got the number to complain." However, several people told us that while their complaints were resolved appropriately, the service did not always maintain the progress. One relative said, "I've spoken to them about [concerns about service] but it doesn't seem to make that

much difference. It gets better for a bit but then it slips back again." It was noted that this related to the timekeeping of care workers and the recurrent issues with staff capacity at certain times of year. The registered manager was working to find a long term solution to these issues.

We reviewed the complaints file and saw complaints were investigated and responded to in line with the provider's policy. The provider offered apologies and took corrective action when complaints were upheld.

Care plans contained a section relating to people's wishes for their end of life care. However, this was a very brief section of the document and focussed on whether people had 'do not attempt resuscitation' orders and funeral plans. In the care files viewed people had either stated they did have a funeral plan, or that they did not wish to be supported with considering this by the agency. We discussed this with the registered manager as the way end of life care needs were explored with people did not seem to be inviting people to discuss their wider views in terms of end of life care and preferred place of death. The registered manager recognised that the format of the questions may have an impact on people's willingness to discuss this sensitive area of support.

The training manager explained they were currently undertaking a training programme for staff based on the gold framework developed by Skills for Care. Their plan was to then cascade this training to all care staff to improve the support they provided to people in the last stages of their lives. The registered manager also submitted a plan which stated they intended to include advanced care planning as part of their spot checks and audits of care plans in order to increase the personalisation and reduce the task focussed nature of this aspect of care plans. This meant there were credible plans in place to improve the quality of end of life care planning in place.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because quality assurance systems had not operated effectively to identify and address issues with the quality and safety of the service. At this inspection we found improvements in this area, but some issues remained.

The registered manager completed a range of audits to monitor the quality of the service. These included audits of incidents, complaints, care plans and reviews as well as surveys and feedback received from people, relatives and staff. The audit of care files included a log of the number of files completed, and whether or not reviews had been completed. However, it was not clear that the quality of the content of care plans had been reviewed as we identified issues with the quality of some care plans and risk assessments. This meant the provider's audit system had not been fully effective in identifying and addressing issues with the quality and safety of the service.

We reviewed staff job descriptions which included clear information about staff responsibilities and accountabilities. It was clear what each staff member's role was in terms of monitoring and reviewing the quality of the service delivered. The registered manager discussed concerns about the completion of work with staff and there were performance plans in place to address where reviews had not been completed, or care plans had not been updated.

Although the registered manager's audits identified issues with the telephone monitoring completion rates, quality of records of care, medicines records and spot checks completed, there were no action plans in place to address these concerns. We discussed the issues we identified during the inspection with the registered manager. They submitted an action plan which included the addition of spot checks for quality by the registered manager, as well as additional training for staff. This meant the provider had plans in place to address the issues found during the inspection. The submission of the action plan and updated care plans showed the registered manager had understood the issues identified as the quality of the updated documents was improved.

Providers are required to notify CQC of certain types of event by law. We reviewed incident forms and found although notifications had been submitted for some incidents they had not been submitted for four safeguarding alerts that the provider had raised with the local authority.

This is a breach of Regulation 18 of the CQC (Registration) Regulations 2009.

People and staff spoke highly of both the registered manager and the office based staff. The registered manager spoke about the care workers employed as the most important asset of the business and was passionate about ensuring staff understood the value she placed on them. The registered manager told us, "The care staff here have good values and I value my care staff. My team has worked so hard since the last inspection. I consider myself very lucky, they are dedicated to their work."

People and staff told us they found communication from the office was clear and the registered manager was easily available for them to talk to if they wished. One person told us, "The office are always very helpful." People told us office based staff contacted them and kept them updated of any changes to their service. One person said, "That's the good thing about them. They are always writing to me or phoning me if there are any changes."

The provider had signed up to the Care Commitment and the six C's of the care commitment were displayed throughout the office. The six Cs are care, compassion, competence, communication, courage and commitment. These values were used to underpin the training delivered to all staff. They also formed the basis of the provider's statement of purpose. Staff spoke about their commitment to providing quality, caring services and this demonstrated the values had been understood and were being applied by staff in their work.

The provider completed regular telephone monitoring of the service. In addition, they completed annual surveys of people, relatives and staff to seek feedback about the quality of the service. The survey results showed that people were happy with the quality of the service and any specific issues raised were addressed with individuals.

The provider also completed a staff survey to seek staff feedback about the provider. This was in addition to opportunities to make suggestions for the development of the service which were provided through regular staff meetings. Staff told us they thought their feedback was listened to and valued by the registered manager. One care worker told us, "Since I've worked here we've had a couple of staff meetings. We got to meet everyone and it was nice to see all the other care workers. We're always on the road. If you've got a double up it's nice to have an idea of who you'll be working with. We get feedback about our work. They listen when we raise things with them."

Although the provider had not developed actions plans as a result of audits and quality assurance mechanisms, they did have a clear business development plan in place. This considered both the risks and opportunities in the local care environment and had strategies in place to ensure the sustainability of the service. The registered manager worked together with the provider, and registered managers from other services within the provider organisation to develop strategies and plans. Records showed the managers within the provider organisation met regularly to discuss themes from the different aspects of the business to ensure knowledge and learning was shared across the business.

The provider kept up to date with best practice recommendations and guidance from Skills for Care. The training manager was knowledgeable about the resources available to them through support organisations in the care sector. The registered manager attended local network and forum meetings for care providers. This ensured the service was both working in partnership with other organisations and continuously learning and developing 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 12 HSCA RA Regulations 2014 Safe care and treatment Measures in place to mitigate risks were insufficient and information about people's medicines was not clear and did not ensure medicines were managed in a safe way. Regulation 12 (1)(2)(b)(g)

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications of allegations of abuse as required.

The enforcement action we took:

We issued a fixed penalty notice of £1250.