Midas Care Limited

Midas Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Midas Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger adults, people living with dementia, people with physical disability, people who abuse alcohol, people with autism or learning difficulties and people with a sensory impairment. The service also supported people who require 'live-in' care staff to support them throughout the day. Not everyone using Midas Care received a regulated activity; Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

Midas Care operates from an office based on the outskirts of Waterbeach. At the time of this inspection there were 270 people using the service.

This comprehensive inspection took place between the 24 and 29 January 2018 and was announced. We gave the service five days' notice of the inspection visit. This is because the provider needed to arrange visits to people's homes so we could shadow staff's care calls and gain consent to telephone people and their relatives.

The previous inspection was undertaken on 3 November 2016. At that inspection the service was rated as 'Good'. At our inspection between the 24 and 29 January 2018 the service had deteriorated to 'Requires Improvement'.

The registered manager had started in post under a different role in November 2017 but had only been registered as a registered manager since 9 January 2018. The previous registered manager had left in November 2017. 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.

Not all incidents of harm, or potential harm, had been referred to the local safeguarding authority. People's care and support needs were not always met by staff in a way which supported people as well they should have been. Staff were recruited in a safe way but their deployment did not always ensure that people were safe. Not all staff provided care that was as caring or dignified as it could have been.

People were not always administered their prescribed medicines safely. Advice had also not always been sought from healthcare professionals when medicine administration errors had occurred. Not all staff followed people's care plans. Incidents were not always identified as being an opportunity for learning and to help drive improvements.

People were enabled to access healthcare services. The equipment that staff supported people with was checked to make sure that it was safe to use. A positive and good working relationship existed between the

registered manager, staff and relevant stakeholders. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were not always supported with their nutritional needs.

People were involved in decisions about their care and relatives or friends helped provide information, which contributed to people's independent living skills. People's care plans contained sufficient information about the person to assist staff with providing person centred care. People were provided with information about, and or enabled to access, advocacy services when required.

Complaints were not always identified and they weren't always investigated in line with the provider's policies and procedures. Concerns were not always acted upon before they became a complaint. Arrangements and procedures were in place to help ensure that people received good end of life care.

The registered manager and provider had not always notified the CQC about events that, by law, they were required to do so. Audits were not always as effective as they should have been which meant opportunities to make improvements were missed. Where incidents occurred these had not always been investigated or acted upon.

An open and honest staff team culture had been established by the registered manager. The registered manager motivated the staff team with regular meetings, formal supervision, mentoring and using experienced staff to mentor and shadow newer staff. Audits and quality assurance systems were not effective in identifying and making the necessary improvements. Staff were supported in their role.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was for not safeguarding people, unsafe medicines' administration, ineffective or no responses to complaints and a lack of effective governance. We also found one breach of the Care Quality Commission (Registration Regulations) 2009 for not notifying us about events that, by law, the provider must tell us about.

You can see what action we told the provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

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.

People were not always safeguarded from harm and opportunities to make improvements with people's safety had been missed.

The local safeguarding authority had not always been informed where incidents of harm or potential harem had occurred.

Although staff were supported with training on how to administer people's medicines, they did not always do this safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's assessed needs were not always met by staff.

Not all staff possessed the skills they needed to support people to be as independent as possible.

People could make choices about their care and staff respected these.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all people's care was as caring, dignified or compassionate as it could have been.

People's preferences and wishes about their care were not always respected.

People's care was provided with privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was not as person centred as it could have been.

The provider had not followed its policy in resolving people's concerns and complaints.

Systems were in place to support people with their end of life care if this was needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured that notifications had been sent to the CQC when they should have been.

Audits, quality assurance and governance systems were not as effective as they could have been.

The provider worked with other organisations including the local authority to help make improvements.

People had a say in how the service was run.

Midas Care

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns which we had been made aware of about the quality and safety of people's care.

This announced inspection was undertaken by two inspectors and two experts-by-experience. Their area of expertise was caring for older people and people living with dementia. 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 inspection took place between the 24 and 29 January 2018. We gave the provider five days' notice to arrange for us to accompany care staff during their work and gain consent from people or relatives we wished to speak with.

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 looked at this and other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

As part of our inspection planning we received, information from those organisations who commission care at the service. We asked for feedback from the local safeguarding authority, and the Clinical Commissioning Group (CCG).

On the 24 and 25 January we spoke with 21 people and 14 relatives by telephone to obtain their views. On the 26 and 29 January we spoke with a further six care staff by telephone.

On the 24 January 2018 we visited the service's office to speak with the registered manager, the lead care

coordinator and a care coordinator. We also spoke with the live-in care development manager, the quality officer, the operations' manager and the senior field care supervisor. We spoke with a member of a nursing consultancy agency who was assisting the provider to make improvements to the quality of service being provided. We looked at the care records for eleven people and these included their medicines' administration records and two new staff recruitment files.

On the 25 January 2018 we accompanied staff and visited four people in their homes. During these visits we spoke with all four people and five of the care staff supporting them.

We also visited the service's head office on the 25 January 2018 to speak with the nominated individual (NI). The NI is the person who has overall responsibility for the management of the regulated activity, and ensuring the quality of the service provided. We also looked at records for the management of the service, staff training and supervision, complaints, safeguarding, accident and incident records and the provider's 2017 quality assurance survey.

Requires Improvement

Is the service safe?

Our findings

Since our inspection in November 2016 the service had deteriorated from 'Good'. During this inspection in January 2018 we found that improvements were needed. Where incidents of harm had occurred or where there was a risk of this happening, these had not been acted upon. These had been reported to the provider's management team. However, they had not followed the provider's policy and reported them to the safeguarding authority. The provider's management team had not used these opportunities to make improvements to people's safety. For example, when staff had allegedly been rough with people. In addition, it was only when we highlighted this that investigations into incidents were reopened. This meant that provider missed opportunities to learn from any safeguarding investigation and this continued to put people's safety at risk.

Investigations into safeguarding incidents were not always undertaken. This meant that the provider had missed opportunities to learn when things had gone wrong and people continued to be at risk of harm or further harm. Where staff had been subject to disciplinary action due to gross misconduct, there had not been any investigations into their actions. This meant that the staff who could potentially need to be referred to Disclosure and Barring Service (DBS) were allowed to leave without any investigation into whether they were safe to go on to care for other people or not. People were not safeguarded from harm or potential harm.

We gave the provider 24 hours to provide a record of a serious incident that had occurred. They were not able to confirm that an investigation had been completed or how the harm had occurred. This meant that people were put at risk of further harm. Incidents of harm had occurred, but a lack of investigations limited the provider's ability to prevent them from happening again.

Not all people's care was as safe as it could have been. A relative told us, "The [staff] can be clumsy. A few weeks ago they left the key safe code showing instead of mixing the numbers up and also left the door unlocked." Another relative told us that staff had not always safely secured their family member's home. Although risk assessments were in place to advise staff to secure people's homes, staff did not always adhere to these risk assessments.

People remained at risk of harm, safeguarding incidents were not always acted upon or reported to the safeguarding authority. Investigations into safeguarding incidents were not always undertaken. Staff and the management team did not adhere to the provider's safeguarding policies. When things went wrong, the safety of people's care had not been improved upon.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they were safe because they had consistent and reliable staff. One person said, "Yes quite safe. They [staff] are nice to me. I mostly have a regular one and feel safe when they are supporting me to get a bath as I have walking problems." A relative told us, "My [family member] feels quite safe and they

[staff] are well trained [at moving people] in my opinion. Family member] has a hoist to get her out of bed and into her armchair and they [staff] safely support her under her arms and legs when doing this."

Staff were trained on how to keep people safe such as with moving and handling and checking equipment. Systems were in place to support people to request assistance using an emergency life-line call system for urgent situations. Staff were able to describe the physical and emotional signs and symptoms of harm, such as unexplained bruising, or if the person became anxious or withdrawn. They also told us who they could report this information to the registered manager or safeguarding authority. One staff member said, "If a person had any bruising or other signs of abuse I would report to my senior staff straight away. I can always speak with the [registered] manager if needed."

Staff were trained and had their competency to administer people's medicines assessed on a regular basis. However, people were not always administered their medicines as prescribed. One relative told us, "I think sometimes [family member] is not safe because [staff] can arrive late and [family member] is diabetic so therefore needs regular meals." The lack of an even spacing between meals put the person a risk of not having their diabetes safely controlled. Another relative told us, "[Family member] was not safe earlier this year when [staff] got their eye drops and ear drops mixed up." The relative went on to tell us how the person's eye had been affected as a result of this but fortunately this was not permanent.

We found that people had not always received their medication according to the instructions. We looked at the medication records for eight people and found that there were concerns for three of these people. Medication prescribed to be taken 30 minutes before food and drink had been administered at the same time as food and drink. This put people at risk of their medicines not working as intended and that their health would be affected.

We saw that people's medicines' records were not accurate and that they did not contain the information that staff needed. One person's medicine had not been ordered in advance, which resulted in it not being administered for four days. The registered manager told us that, "Staff should have alerted the office when there was less than seven days of medicines left." They said, "This should also have triggered an incident." We found that there was no record of this incident being investigated. This put people's safety at risk.

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

Systems were in place to support people who were at risk. Risk assessments were in place and provided guidance to staff as to how to minimise risks such as falls, choking and malnutrition.

Staff were provided with information about whistleblowing. Staff told us that they felt confident to report any concerns about people's care. A staff member said, "I would not hesitate to report any other staff if they fell below the required standards." Whilst there were concerns about safeguarding not being report accurately, some staff did know about who to report these.

The registered manager told us that people's levels of dependency were assessed and based upon their needs the necessary staff were then put in place.

Although sufficient staff had been recruited to meet people's assesses needs, their deployment did not always ensure that people were safe. This had resulted in some staff having to cut care calls short as well as some staff not being able to provide the full support to people. This was evidenced by the people and relatives who told us that care calls were up to three hours late. One person said, "I have never had a

completely missed call." A relative told us that, "They [staff] always turn up eventually." Another told us, "Care [call times] are not good. My morning call is supposed to be 8-8.30am but they [staff] are not coming until 10-10.30am." A third said, "I am still waiting for [my care call] now and it's 9.50am [for a 9am care call]. I don't know my time frame they [the provider] didn't give me one and I have four calls a day. They [office staff] don't phone me and if I call them. The answer is always 'they [staff] are on the way'. Not had them miss coming but they are late." One relative said, "Since the regular [staff] stopped coming they can be up to an hour late. If staff don't come on time [family member] will struggle to try to shower himself on the shower stool. In the evening they can go after 10 minutes." Another relative said, "I have issues if non regular [staff] come late as [family member] then tries to shower himself which can be a safety worry." We found that where staff provided care in a local area staff had time to travel but in more rural areas this was not the case. This meant that staff had to cut care calls short or rush the care to catch up. This put people's safety at risk.

Staff continued to be recruited safely with a Disclosure and Barring Service check to make sure they had a clear criminal record. This was as well as a process to validate staff's photographic identity, employment history, references and staff signing a declaration that they were fit and healthy to carry out their role of employment.

Infection control and prevention training was provided to staff. Staff adhered to good hand hygiene standards and that they wore personal protective clothing appropriately. None of the people or relatives we spoke with reported any concerns about hygiene standards. One staff member said, "We get spot checked to make sure we are wearing aprons and gloves and that we are wearing clean clothing." We saw that staff wore their protective clothing during our visit.

The provider had an electronic care call and recording system in place to record when incidents occurred. We saw that where things had gone wrong, for example medication errors and missed calls, these records had been completed. However, not all of these had been investigated. This limited the provider's ability to make the necessary improvements.

Requires Improvement

Is the service effective?

Our findings

Since our inspection in November 2016 the service had deteriorated from 'Good'. During this inspection in January 2018 we found that improvements were needed. Although staff had been trained on various subjects or given support to improve their English language, we found that this training and support was not always effective.

There were many comments from people and relatives in regards to communication with those staff whose first language was not English. One person said, "They [staff] are alright but [the communication] can be an issue and I prefer to [not have staff I can't understand]." Another person told us, "I have to talk to them all the time to tell them how to do things, as they don't understand what I mean. I asked for a flask of coffee to be left and [the staff] made me a cup [of coffee]." A third person added, "Yes they [staff] wash and dress me well but the ones that can't [communicate] well don't understand me, so don't know what I like and don't."

We also observed staff who did not always communicate clearly with people. One person told us that this made them "anxious and confused". A relative told us that they could understand staff but their family member "sometimes struggles as he doesn't hear too well." Another relative said, "Their [staff's] cooking is poor and they can't read the instructions on how to cook the food in the microwave." This meant that people were at risk of their care not being provided in a way they preferred it to be.

People's needs and ability to make decisions about their care was assessed. People's care needs were determined and care plans were then tailored to meet each person's needs. Following this process staff were then appointed to care for people based upon the training staff were provided with. One person said, "I can't fault them. I have had them [provider] for three years now so they know me well. I decide everything about my care."

Based upon people's needs a planned programme of training was in place for staff and this was based upon good practice. Subjects covered included diabetes awareness, dementia care and different types of catheter care. This was as well as support for staff who required support to speak and write English better. One staff member told us they had undertaken training on moving and handling, safeguarding investigations for managers, the Mental Capacity Act 2005 (MCA), and infection prevention and control. Other staff told us about their diabetes, dementia care and risk assessment training.

Where people were at risk of not drinking or eating, food and fluid charts were in place. Where this situation continued referrals were made to health care professionals, such as a dietician or speech and language therapist. This helped promote people's wellbeing. One person told us, "My family shop for me and the care staff will take a meal out of the freezer in the morning ready for lunch time. They will say "what do you fancy today?" And, "I order [name's] shopping weekly on line. It would be good if staff could let me know if [family member] is running low on anything instead of letting it run out. The previous agency we had did do this."

Where people needed health care support, staff enabled this by providing information about the person's health condition as well as arranging visits to, or by, a GP. This was as well as liaising with external

organisations such as a hospital or community nurse when a person returned home to be cared for. One person told us, "A few weeks ago I fell out of bed. When they [staff] arrived in the morning and found me they called the ambulance and waited until it arrived." The registered manager said that they had discussed this incident with the person who felt that no further support was required.

Other health care professional interventions had been arranged by the provider or with the Clinical Commissioning Group (CCG) and these were in place such as for administering insulin, pressure care and monitoring of people's blood for specific health care needs. This showed us that people were supported with their health care needs.

The 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. The authorisation procedures to deprive people of their liberty for community are applied for through the Court of protection. We checked whether the service was working within the principles of the MCA.

Staff had a good understanding about people's mental capacity and where they needed to support people to make a decision. They were supported to have maximum control of their lives and staff supported them in the least restrictive way possible. One person told us, "They [staff] are nice and polite and do ask before starting to do anything." Another said that staff gave them a choice and that staff "always check and ask me first."

People's care plans included a detailed assessment of the person's mental capacity for each aspect of their care. The registered manager was working with people's social workers if they had determined that restrictions were taking place in the person's best interests. One person said, "I get to choose what I want to do and who provides my care." A staff member told us, "Making sure we always assume people can decide what they want to eat, wear, or do is important. It's their choice and I can only support the person by prompting them to eat." However, we found that not all staff prompted people living with dementia to be supported with their food intake. Relatives of people living with dementia told us that if their family member told staff they were not hungry staff did not leave any food for the person to have later. One example was, "They [staff] ask [family member] if they are hungry and if they says 'no' they don't prepare a meal. They should encourage them to eat something by offering them a choice of meal options." Another relative said, "Some of them [staff] are okay but the others rush [family member] and don't even offer or show [family member] a drink.

Requires Improvement

Is the service caring?

Our findings

Since our inspection in November 2016 the service had deteriorated from 'Good'. During this inspection in January 2018 we found that improvements were needed. The lack of action and oversight by the provider meant that staff were not always able to provide a caring service as this had limited the time staff had to spend interacting. Many people's care was rushed and not at a time they preferred. Examples we were provided with about the quality of people's care included one person who said, "Since the regular one [staff] stopped coming they can be up to an hour late. On an odd occasion they [the provider] will call but we usually end up calling the office," A relative told us, "They [staff] are fairly on time coming but sometimes don't stay the full time, they rush and go." Another relative said that when the regular care staff were off, "My [family member's] partner then has to watch them [staff] as they don't deal with [family member] as well. Their continence pads need pulling up high onto their waist so the elastic does not rub them. Others [staff] don't do this and it has led to redness and blistering. Also they [staff] don't always pull the slide sheet up fully on the bed."

Another relative told us about their family member's care. One staff said about their family member, "Can't you look?, to [family member] because [staff] did not even know that [person] is blind.' It upsets them. Staff have been nasty to me when I try to tell them." Another relative said, "My regular one [staff] is excellent but I do worry about others. They don't talk to [family member] much, don't offer them a drink or support them as well when turning them in bed." We found and were told by people and their relatives not all people's care was as respectful or caring as it should have been. This was also confirmed in the provider's November 2017 quality assurance survey.

Some people told us that their privacy and dignity was respected and that their independence was promoted by staff. One person told us, "Fully respected every time. They [staff] close the door and curtains and ensure I am kept warm." Another said, "Very good when bathing me as a shower makes me ill. They close the door and blinds and hold a towel up for me to step into." Many people and relatives however, told us that the quality and standard of care was mixed and that when alternative staff to their regular staff provided care the care was not as good. Comments from one person included, "My live-in carer is excellent and most kind and considerate but the ones that cover not so good or up to the mark." Another person told us, "I get [tired] of repeating things to all the different staff who come." One staff member explained to us how they, "Always engage in conversation and have a laugh too. Explain what I am doing at every stage of the person's care."

Some people told us that staff made them feel important and not just a number. We observed staff asking people if there was anything else they needed doing and if they were in any discomfort. One person told us, "My care [staff] is brilliant when helping me shower etc. I feel more relaxed with a male carer." Another person said, "The staff are good. They are all very pleasant." A relative told us, "They are lovely ladies [staff]. They love [family member] and loves having a laugh and joke with them. They do know them very well, especially the experienced ones who have been going to them for a while now."

Other people however, commented less favourably about non-regular staff by saying, "Last week a young

[male staff] came, rushed, pulled the quilt up then pulled [family member's] pants off and did a quick wash leaving them uncovered. I have told the office [staff] I want a female to do this." A relative told us, "[Family member] has a double up call of a male and female. I request that the female does their personal care but they sent a [male] last week to change their continence pads. We have indicated we don't mind if they [staff] are mixed." People's wishes were not always respected and this compromised their dignity.

Requires Improvement

Is the service responsive?

Our findings

Since our inspection in November 2016 the service had deteriorated from 'Good'. During this inspection in January 2018 we found that improvements were needed. The provider had not always followed their complaints process for acknowledging and responding to complaints within their timescales. Examples included one person who had complained about late calls in November 2017 but this had not been responded to until 23 January 2018. This had been over two months' delay. Another example was office staff who told us that they could not find any records for responses to complaints about a late care call and said, "It must have slipped through the net."

There were inconsistencies in responses to concerns people or their representative had reported. For December 2017 we saw there had been 18 complaints about missed calls. One person told us they had complained about late care calls and said, "I have left messages on the answerphone but they [office staff] never respond." Another person told us, "I ring the help desk and then end up ringing again because nobody calls me back." A relative said, "I have complained about the office staff. Nothing has improved. I have asked for letters to come to me, as next of kin, so they don't confuse [family member] but they still send them there." Another relative told us they had raised concerns about non-regular care staff not offering their family member a drink and not staying the full care call duration or talking to them. The provider's office staff also did not get back to the relative. People also told us and we found that their complaints had not been acknowledged. People's and relatives' complaints were not always investigated and they were not always resolved to people's reasonable satisfaction. This prevented the provider from taking on board any potential learning and this limited the opportunities to prevent incidents from reoccurring.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that they had been involved in the assessment of the person's care needs. Information was also sought from external agencies, such as the local authority, CCG, social worker and health care professionals, who knew the person. A care package was implemented based on the information gathered and in consultation with the person. Most people's care plans were an accurate reflection of the person and their needs. They included details about the person's individual needs, such as how they wished to be cared for and by whom. They also provided staff with information including the time the person wished staff to provide their care. One person said, "I have a lovely Romanian lady who even teaches me to speak Romanian. She is very good at English and we get on really well." One relative told us, "[Family member] needs them [staff] to do all the lifting, washing, dressing and changing the clothes. The experienced ones do it very well and I can't fault them. Having the same staff is important for [family member]."

Support was provided to people who lived in the community to access local facilities, their friends and peers as well as taking part in social stimulation such as singing, drama and music. One person told us, "I need help from staff in the morning but after that I can do things for myself.

The provider had introduced an electronic care call monitoring and recording system which they were continuing to develop. The registered manager told us that if people wanted hard copy care plans they could have these. We saw that hard copies of care plans were available in people's homes. One person told us about a review of their care by saying, "Yes I do all that with them [staff] and a copy is here." Another told us, "I do this with my [family member] who can also have a say into it. Yes, a copy is here."

A nursing consultancy agency was assisting the provider to develop a new end of life care policy based upon the latest resuscitation guidance. Although the guidance had been published in January 2017 this new process was only now being adopted. The Live-in care development officer told us about how people were supported should the need arise. They told us, "As well as people with a do not resuscitate record we engage with the person and focus on their wishes. We also liaise with the NHS palliative care nursing team for any anticipatory medicines. Staff are also made aware of any preferences such as what to do before and when the person died." Where people had required palliative care, records showed that they had been supported to have a peaceful and dignified death. No one at the service was receiving palliative care at the time of this inspection.

Requires Improvement

Is the service well-led?

Our findings

Since our inspection in November 2016 the service had deteriorated from 'Good'. During this inspection in January 2018 we found that improvements were needed. We found from records we held that notifications involving people's safety had not always been reported to the Care Quality Commission as required by law. This put people at risk of continued harm and limited the information available to external organisations in responding to the safety of people using the service. This also put people at risk of not being as safely supported as they could have been.

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

The registered manager had started in post under a different role in November 2017 but had only been registered as a registered manager since 9 January 2018. The previous registered manager had left in November 2017. 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.

We saw that the provider was not correctly displaying their previous inspection ratings poster in their head office. The registered manager corrected this before the end of the first day of our inspection by prominently displaying their rating's poster.

A process was in place to enable health care professionals to access people's electronic medicines' and health records. The nominated individual told us that [mobile phone] signal issues for the system were being looked into and that any urgent changes could be sent to staff.

Most people told us they had been asked for their views about the quality of their care. Samples of these were, "Yes I have had a survey and sent it back" and "Yes had one [survey] recently and sent it back. It was a tick box one. But you could add comments." However, some negative comments included those about quality assurance that was not effective including investigations into complaints not being undertaken in a timely manner. Three complaints were dated the day before we undertook our announced inspection but these were outside the provider's timescales. This meant that people were at risk of not receiving care that they needed or having their concerns responded to in a timely manner.

The provider had a range of audits, quality assurance and governance systems in place including those for care plans, medicines administration records and complaints. We found that these were not effective. Where incidents had occurred an investigation had not always taken place. Medicine audits had not identified the issues we found during our inspection and therefore improvements had not been identified. This lack of recognizing when an investigation was required limited the provider's ability to make improvements before things went wrong again.

The electronic care call and recording system's information could be misleading as information on 23

January 2018 had indicated that there were 235 care calls recorded as late. The data provided was not an accurate reflection of events that occurred. It was therefore not clear which calls were late, missed or completed. As a result of continuing concerns we found the lack of effective actions being taken for areas including poor care and incidents of harm did not prevent them from happening again.

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

The new registered manager was working with the provider, the local authority and various care consultants in improving the quality of service that was currently being provided. All of the staff we spoke with were complimentary about the improvements being made. We found the quality of the service currently provided had to change for the better and that the implementation of this situation had been duly recognised by the provider's management team. The registered manager said, "We are on a journey and there is more to do but we will get there." Staff also spoke highly about the new leadership, a more open staff culture and one where staff were supported to challenge situations they felt they weren't comfortable with. Additional staff resource had also been put in place to analyse complaints and to lead the coordination of people's care. One person told us, "It [their care] was not good but it is getting better."

The nominated individual told us that they had recognised where mistakes had been made in the past. This had been with regard to taking on a lot of additional care packages for people from another provider in a short period. This they told us had been an error of judgement. This was as well as promises from the previous care provider to provide staff, which had not happened and this had also created pressures to provide care that was of the quality they expected.

The nominated individual and registered manager both had a shared passion to make things better. Information was shared with these external stakeholders where this was appropriate. We found that this was helping to drive improvement. In addition, they were both working hard to make the necessary improvements. This was with investigations, incident recording, providing more specialist staff resource with clinical governance, safeguarding and care scheduling.

All staff we spoke with told us the registered manager was frequently in the office and seeking staff's views and suggestions. One staff said, "It's [the atmosphere] much calmer. We have extra staff in the office, more access to specialist knowledge and a new clinical lead joining us soon which will also be a great help." The registered manager and all staff we spoke with knew what was expected of them, such as the standards expected by the provider, their values and attitude towards the people they cared for being positive.

We saw that changes were starting to be implemented and that a reduction in people being cared for following a local authority embargo had helped reduce the risk of harm to people. This was as well as handing back people's care to the local authority where it could not safely be maintained to the required standard.

Increasing staff's skills and knowledge was seen as a priority by the registered manager. This was beginning to make a difference. This was due to additional staff resource and staff with specialist skills. People had mixed views about the quality of their care. Not everyone we spoke with felt listened to, although one person told us they were, "Quite satisfied with the way things are running at present." Another said, "Sometimes communication [with the office] can be an issue."

However, other people's comments about the quality of care provided included, "Needs to be better. Care call times are erratic and also language barriers are an issue," "Not really, it is not very good [quality]," "Poor.

If you call them [office staff] you get a standard answer of 'we will look into it' but nothing is ever done and they never get back to me" and, "Would be nice to give us a time frame instead of calling whenever. I have asked them [the provider]." The person went on to tell us that they still did not have a regular call time. This showed us that where the provider was made aware of people's concerns about the quality of their care that improvements were not always made.

The registered manager told us that they motivated the staff team with meetings, supervision, coaching and leadership. Staff had the support they needed which included spot checks on staff's performance to check they were working to the standard expected by the provider, shadowing experienced staff and supervision. These opportunities to support staff were used to provide positive feedback and encouragement. All staff we spoke with told us they had met the new registered manager in person including staff who worked some distance from the provider's head office. This was as well as staff describing to us a team culture and that if any staff needed help then this was provided. One staff told us, "It has been hard work over the past few months with all the changes to care call rounds, new staff and those in the office." Another said, "I get lots of training, supervision, and support. I can ask at any time for help if needed. We have the [registered manager's] contact details."

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 18 Registration Regulations 2009 Notifications of other incidents The Care Quality Commission (CQC) had not always been informed about events that it should have been. Not all incidents were notified to the CQC without delay.,

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always safely supported with their prescribed medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents where people had not been safeguarded were not reported to the local safeguarding authority. Investigations into safeguarding incidents had not always been undertaken.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always responded to. The provider's policy for complaints was not followed. People's complaints were not resolved to their reasonable satisfaction.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit, quality assurance and governance systems were not as effective in identifying and driving the necessary improvements.