HH Community Care Limited

Stocksfield and Haltwhistle

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an announced inspection of this service on 20, 21, 26 and 30 June and 6 July 2017. At the last inspection in November 2016 the provider was not meeting Regulations 12, 17 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and these related to safe care and treatment, including medicines, good governance and the requirement to display a performance rating. They were also not meeting Regulation 15 of the Care Quality Commission (Registration) Regulations 2009 relating to notifications. Notifications are changes, events or incidents that the provider is legally obliged to send us within required timescales.

Since our last inspection in November 2016 the provider had sent us weekly action plans of how they were going to address the concerns and meet the regulations. This inspection was to ensure concerns had been addressed and that the provider was now meeting the regulations.

At the last inspection in November 2016 the overall rating for the service was required improvement with an inadequate rating in well led.

The overall rating for this service is now inadequate and the service has been placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to

varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The provider was given short notice because the location provides a domiciliary care service into people's homes. We needed to make sure that some notice could be given to people who used the service and also to ensure that key staff would be present at the provider's offices.

Stocksfield and Haltwhistle provide personal care and support to people within their own homes in the communities of Hexham, Haltwhistle and the surrounding areas. The service is managed from an office on the outskirts of Stocksfield.

168 staff currently provide support to 268 people. The service is available for a wide range of people, including those who are older, those with mental health needs and those with more complex 24 hour healthcare requirements. The organisation on average completed 4452 calls per week, which provided people with 3272 hours of care, although this can vary due to the nature of the service. Many of these calls, for example, were to deliver personal care or administer people's medicines but other calls may have been to complete housework or do shopping for an individual. The service also offered an enablement service, which provided people with support to remain as independent as possible, avoiding social isolation. This included help to visit shops or other venues important to them.

There was not a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run.

There had not been a registered manager since the previous one retired. However, a new manager had been appointed a few weeks prior to our inspection and confirmed they were about to start the CQC application process. A new managing director had been appointed in November 2016 and since our last inspection a new nominated individual had taken over. We recognised that the new management team were dealing with issues that were historic in nature and had been embedded into the providers culture.

We had raised concerns in connection with the management of people's medicines at the last two inspections we undertook at the service. There had been an improvement to the format in which medicines were now recorded. However, we continued to find discrepancies in the way in which medicines were managed. Out of the 14 people we visited, we found errors of some description in the way staff had managed people medicines in 11 of these people. We also found that the medicines policy had not been updated in line with National Institute for Clinical Excellence (NICE) guidance published in March 2017.

Accidents and incidents were recorded on the providers IT system, but we found that actions had not always been recorded and no analysis had been completed to learn from these or spot any trends forming. We asked for a copy of the provider's business continuity plan a number of times and were eventually sent it over a week after the initial request.

Staff had not always followed the requirements of the Mental Capacity Act 2005 (MCA) as records were not always in place to confirm any best interest decision's had been made or to record if a person lacked capacity. Although we overheard people being asked for their consent before staff embarked on any personal care, we also found some people's records did not specify as to why particular actions were

followed by staff.

People had an assessment carried out when they started using the service. Care records had been updated and reviewed but not in all cases and therefore did not always give clear guidance. Care staff relied on relatives, people and other care staff who verbally shared information with them regarding people's personal care needs.

Surveys had not been completed to gain the views of people, their relatives or staff at the service.

Service audits to monitor and continually improve the service were not effective or were not in place. The shortfalls we found had not always been identified, particularly with regard to medicines.

People knew who to contact if they had a problem or complaint. Verbal complaints reported were logged on the provider's IT system. People told us that the provider looked into any complaints they had raised, but because sections were not always completed, we were not always able to see the outcome or the lessons learnt from each complaint or if indeed the complainant was satisfied.

Staff were recruited safely with a suitable induction completed. Staff had received a range of training, however, we were provided with a training matrix which was not accurate and therefore we could not be sure that staff had received the training reported.

At their supervisions and appraisals staff had the opportunity to discuss concerns and any further training needs. However, not all staff received regular supervision or an annual appraisal. Staff did not feel as supported in their work as they had previously been. However, we recognised that the provider had been subject to a number of staff changes, including within the management team, which was likely to have caused a feeling of unrest within the teams. This was now being addressed

People and their relatives felt safe, cared for and supported by care staff in their own homes. They told us they were treated with kindness and respect and were complimentary about the staff who supported them.

However some people were not happy as they did not have consistent care staff. Where there were missed visits the provider took action to try and prevent the risk of this happening again, although the systems used were not robust. The provider did not always inform people of changes to their rotas or planned care visits.

People were supported to eat and drink by care staff who knew what their food preferences were. The management team consulted health and social care professionals when needed.

The provider had sent the Commission notifications in line with their legal responsibilities.

We found four breaches in relation to Regulation 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to, the need for consent, safe care and treatment, staffing and good governance.

We made one recommendation in connection with the provider's rota system.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed in a safe and appropriate way. Risk assessments were not always in place and up to date.

Risk assessments were not always recorded fully.

We have recommended the provider reviews their governance procedures to ensure that people are receiving their allocated time during calls.

Pre-employment checks had been completed on staff prior to them starting work. Care staff were aware of the procedures to follow to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff had not always received supervision and annual appraisals as they should have.

People were supported by care staff who undertook the training to help support them effectively. However there were discrepancies with reported training and what staff had actually completed.

The provider had not always protected people's rights in line with the Mental Capacity Act 2005.

People were supported to access health and social care professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives felt care staff were very kind and caring in their approach. However, the provider had not taken action swiftly to promote a caring approach.

People were involved in how their care was provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had an assessment of their needs carried out before they received care. However care records did not contain all the information necessary to guide care staff about how to meet people's needs in a consistent and safe way.

People were aware of who to contact if they wished to make a complaint but complaints were not always recorded with the action taken.

Is the service well-led?

Inadequate

The service was not well led.

There were no robust systems in place to regularly monitor the service to ensure good quality care was being provided. The audits which had been carried out were not effective in identifying the concerns we found.

Surveys had not been carried out to gather the views of people, their relatives or staff.

People recognised a positive change in the management team more recently. There was also a new manager in place.

Stocksfield and Haltwhistle

Detailed findings

Background to this inspection

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

This inspection took place over five days on 20, 21, 26 and 30 June and 6 July 2017. The inspection was announced and we gave 48 hours' notice. This was because the location provides a domiciliary care service and we needed to make sure key staff were available during our inspection.

The inspection team consisted of one inspector, one pharmacist inspector, one expert by experience and one specialist advisor. 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 specialist advisor had a background in governance and quality assurance.

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.

Prior to the inspection we reviewed information we held about the provider, including previous inspection reports, notifications and concerns we had received. A notification is information about important events, for example, serious injuries or safeguarding concerns which the service is required to send us by law. We spoke with the local authority safeguarding team and commissioners for the service and also contacted Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We contacted a variety of healthcare professionals, including two care managers from the local authority, one occupational therapist and two general practitioners. Where we received a response, this was used to support the planning of the inspection.

During our inspection we visited 14 people in their own homes and also spoke with six family members. We contacted 23 people and their relatives by telephone to ask them their views about the service.

We spoke with 20 members of care staff either by telephone, during visits with people or at a team meeting which we attended. We also spoke with the nominated individual, the managing director, the newly appointed manager, three care and support officers and three schedulers.

We reviewed 15 people's care and medicine records. We looked at the personnel records of six care staff, which included recruitment and training documentation. We checked a range of documents in connection with the management of the service, including complaints, policies, and minutes of meetings. We also reviewed all quality assurance documentation.

Inadequate

Our findings

At our previous inspection in November 2016, we found a continued breach of regulation 12 in relation to the safe care and treatment which included, management of medicines, accident reporting and recording, risk assessments and lack of detailed contingency plan. Following that inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we saw that some improvements had been made in the way that medicines were recorded with local pharmacies providing people with detailed medicine administration records (MARs) and staff receiving additional training in administration of medicines. A MAR is used to record prescribed medicines for a person and usually records when to take the medicine, the dose and how often people should take. Senior staff had also implemented a medicines risk assessment to work alongside other documentation and had updated care plans and other risk assessments required to keep people and staff safe.

However, we still found issues with medicines management.

Out of the 14 people we visited we identified 11 where there were a range of concerns in connection with the administration of their medicines. Including for example, codes used incorrectly, staff signatures missing or added incorrectly, information on how to administer particular medicines not available, medicine administration records missing, instructions for medicines which should be administered at particular times not being followed and doses on medicines which did not match medicine administration records (MAR's).

One person we visited was prescribed Levothyroxine. This medicine should be given 30-60 minutes before food. This detail was not recorded in their records and one staff member confirmed the person had this medicine with their breakfast along with other medicines they were prescribed. The provider has now confirmed that they have discussed the administration times with the prescriber and recorded this within the care records

We visited one person and found staff had signed their MAR but this person had, in fact, not been administered particular medicines as they were no longer prescribed to them. The same person had other medicines administered to them but staff had not signed their MAR. The same person had no risk assessment in place to ensure they self-administered a particular medicine safely. This meant that we could not be assured that the person had received their medicines safely as prescribed.

Another person we visited required staff to support them with the application of topical medicines. Topical

medication refers to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. We found that there was no clear direction to staff on how these creams should be applied or where, which meant staff could have applied the creams to the incorrect area of their body.

One person we visited required thickeners to help them with their swallowing difficulties, but did not use them in all food or drinks. We found no care plan in place to provide staff with information about how they should support this person fully with their assessed needs regarding this.

People who were prescribed transdermal patches did not always have clear instructions on their MAR's and staff did not have 'patch' application charts to help them determine where they should be placed on a person. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin into the bloodstream. We also found gaps in MAR charts so were unable to be assured that people had these medicines administered to them as directed.

One person was administered a particular dose of paracetamol as indicated on the medicine itself, but their MAR chart indicated a lesser dose. We could not be assured which was the correct dose and what dosage staff had administered at any one time.

We found no blank MAR's available in people's homes to allow any dose changes to be recorded. For example if creams were prescribed by district nurses or antibiotics by GP's.

When we returned to the provider's offices we were unable to locate older MAR's due to poor archiving and also found that MAR's were not regularly returned to the providers office as often as they should have been.

The National Institute for Health and Care Excellence (NICE) in March 2017 published new guidance for domiciliary care providers, such as Stocksfield and Haltwhistle. We had mentioned this up and coming guidance to the provider in November 2016. However, when we visited we found that the medicines policy had been last reviewed in February 2017 and did not include best practice guidance as per NICE.

Care records had not all been updated and risk assessments (if in place) had not always identified issues we had found.

We found a number of medicines risk assessments either not in place or incorrect. One person's risk assessment in connection with their medicines stated that they had no problems with 'applying creams', and yet we found staff applying creams for them. The risk assessment made no mention that medicines were left out for them to take at a later time which meant precautions were not fully taken to ensure this person's medicines were taken or administered safely.

Accident and incident reporting was still not robust once reported by staff as this was not always checked or followed up, recorded correctly or analysed for trends.

Accident and incident information was inconsistently reported and recorded which impeded any meaningful investigation. We saw that actions were not always fully recorded or followed up and the provider's IT system was not always used to its full potential with incorrect coding of accidents and incidents. The use of incorrect coding made identification of these occurrences more difficult to identify and monitor. For example, one person had been found by care staff on the floor. The outcome recorded on the provider's IT system stated, "[Staff name] is going to take over and wait for the ambulance." There was no further outcome recorded so we could not be assured that the person had gone to hospital, been treated or returned home. The managing director told us that they planned to meet with the software owners to

further develop the system and provide more detailed training to staff.

A comprehensive emergency contingency plan for the service was still not fully in place.

We asked for a copy of the business contingency plan a number of times, we were told it was still work in progress and would be ready in the coming week as currently in draft. A business contingency plan details what action a service would take in the event of an emergency, for example if the weather was so poor it did not allow staff to travel and provide care to people in their homes or if there was a major IT failure. This document was not available at the last inspection in November and highlighted to the provider as not being in place. On the 10 July 2017 the provider sent us a draft copy of the plan and told us it was expected to be finalised by August 2017.

These were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt safe with the service they received and the staff provided. Comments included, "The service is excellent, the same person visits me every week, I am physically disabled and she knows exactly what to do to keep me safe. The carer is excellent with keeping the house safe and tidy and I can trust her with my personal belongings"; "It's reassuring to feel that you're in safe hands when cares are around" and "I have no concerns with my safety, the girls are all very good."

People also felt that staff dealt with their medicines well. Comments included, "I couldn't fault their dedication in making sure I get my medications on time" and added "The carer will take time to sit and explain what effect the medication will have on me before I consume it." People's comments regarding medicines were based on trusting relationships with staff rather than the mechanisms of medicines management.

Care staff were knowledgeable in how to recognise signs of potential abuse. They were able to explain how to report concerns and there was an up to date copy of the service's safeguarding policy and procedure to support staff members.

Recruitment records confirmed all the necessary pre-employment information had been received. This included an application form, suitable references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers prevent unsuitable people from working with vulnerable people who use care and support services.

We received mixed views about staffing and the timings of visits. One person showed us their rota and said, "I get various girls coming, but I know them all. They are all good…some better than others. My only complaint really is that they don't let me know when they are going to be late and it would not take much to ring me." Another person told us, "They [care staff] are sometimes late or someone else comes I am not expecting. I suppose they do their best…it's the people who do the rotas who need to do it better." A third person told us, "I get my rota sent out to me. I usually have the same people, but it can be different if they are on holiday." A fourth person said, "Sometimes staff don't stay the full time. They finish a bit sooner and then go. It would be nice if they stayed to have a chat with me." Office staff confirmed that they often did not have care staff to cover the rota until the last minute and that this sometimes meant they had to go out themselves. There were 22 missed calls recorded between 1 January and 23 June 2017 and the provider told us they tried to ensure that where this had occurred that this did not happen again.

Other comments from people who used the service included, "Staff are generally on time"; "Even when my

regular carer is unavailable, there's always enough carers on hand to oversee I'm ok"; "I have three carers visit me, one in the morning, one in the afternoon and one in the evening, sometimes there is slight conflictions from one to another in the duties they do and sometimes the timings are wrong. At times I've noticed a carer doesn't stay for the full shift" and "My carer is always on time when she visits me twice a week and that's great, as I always feel prepared and look forward to chatting to her".

Although there were mixed views on the rota and timings, we also received many positive views on the way staff changed around call times when people asked for this. One person told us, "If I've been out I'll say can you come a little later…they accommodate me"; "I have had to cancel calls in the past due to visitors or one thing and another. There is never a complaint about it and the office staff or carers just rearrange" and "I have had a number of hospital appointments and they are absolutely fine with cancelling at short notice and rearranging."

We spoke with staff about rotas and the shifts they covered. Some staff felt they were contacted more than others to cover care calls and felt that the provider should share the requests better.

When we looked at staffing rotas we found that staff were often covering shifts back to back. This meant there was normally no time allocated between calls for travel. Staff confirmed that this was the case. This meant that people may not have been receiving the allocated amount of care due to the timings of staff rotas. At a meeting we attended, senior staff told care staff that travel time and rotas were being currently reviewed.

We recommend the provider reviews governance arrangements with regard to staffing to ensure that people are receiving their calls at the times agreed.

The service had experienced staffing issues due to care staff leaving, planned sickness and unplanned short notice sickness and holidays. The management team had needed to prioritise visits and told us they had managed to cover the shortfalls. Care staff told us they worked extra hours and we were made aware by office staff (trained in care) that they, at times supported hands-on delivery of care when they were short. The managing director said, "It's been tricky these last few months. There has been a lot of change and yes, some staff have left; but we are starting to see light at the end of the tunnel now. We have a new manager and new staff starting all the time." We were aware that recruitment in the rural area in which the service worked was demanding as resources (potential staff) were limited and as care packages were spread over a huge area this had created a challenge. The managing director told us that a new role had been implemented and a member of staff had been appointed to assist with the additional recruitment of staff.

Requires Improvement

Our findings

At our inspection in November 2016 we found a breach in regulation 17 in relation to good governance. The provider had not maintained complete records for people with regard their mental capacity or recorded any best interests decisions made on people's behalf. Following that inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we found records regarding people's mental capacity still lacking in detail.

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

One person we visited, for example, was supported by staff to limit the amount of sugary items they ate. However, we were unable to see any record of the best interest decision made regarding this, or any record to support this in their care plan. We spoke with the nominated individual about this who later confirmed that there had been meetings with various healthcare professionals and the person's relatives and were in the process of updating the person's records accordingly. They confirmed that staff had acted in the person's best interests. Although staff were acting in the best interests of the person and appeared, when asked, to understand the core principles of the Mental Capacity Act 2005. We were not able, at the time of the inspection to confirm if the person had capacity or if the provider was acting in accordance with the Mental Capacity Act 2005.

Another person we visited was prone to ripping up paperwork and had fluctuating capacity. Staff had been putting documents out of reach but were now leaving the records in a drawer. We, however, found no record to confirm who had made those decisions and if it was in the person's best interests.

We also found that the provider had not put in place capacity assessments or recorded best interest decisions made on behalf of people, particularly (but not only) in connection with people who were paying for their care privately.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 in relation to need for consent.

New care staff received induction training when they began working at Stocksfield and Haltwhistle. The provider had used the Care Certificate to support new staff without experience of working in care for their learning and development. The Care Certificate is a set of national standards that social care and health workers should demonstrate in their daily working life. New care staff 'shadowed' an experienced care worker until they felt comfortable to work on their own. The amount of shadow shifts depended on the new staff's previous experience and they usually undertook three or four. Once new staff had completed the provider's induction there was a system to record their competence which included spot checks.

The majority of the staff team had undertaken previous training in a variety of subjects but the nominated individual and managing director had felt that after the last inspection, the training programme was not robust. They had purchased a new training package for staff which was specifically tailored around the completion of MAR's and the administration of medicines as part of the three day training package. Training also included, for example, infection control, first aid, food hygiene and fire safety. Staff who had completed some of the training told us, "It was much better than what we had before"; "I normally don't particularly like training, but this was excellent" and "The training was very good and I really enjoyed it."

Competency to administer medicines safely had been checked in most staff records we viewed. The provider sent us a training matrix which recorded all staff training and when it had been completed. The managing director admitted they were behind on the training schedule due to the number of staff involved and because of staff shortages. They said they had delayed the programme due to this.

After we had spoken with a number of staff we discovered that although the training matrix showed staff had completed medicines training as part of day one of the new training package, this was not always the case. Staff told us that the medicines training had not taken place for everyone because of 'some issue arising with the medicines policy'. In an action plan we received on 20 April 2017 the managing director advised us that 100% of staff had completed day one and two training. We also found that the training records for some people did not match the training matrix or what staff had told us. For example one staff member told us they had not had recent moving and handling training. When we checked the training matrix it stated they had received training in February 2017. For the same person the provider's IT system showed they last received moving and handling training in June 2014. Another person who had received moving and handling training in February was not recorded at all on the provider's training matrix.

This meant information we had received was inaccurate and gave a false representation of actual training.

Care staff received formal supervision and an annual appraisal to support them in their roles and identify any future professional development needs. There was a programme on the provider's computer system to identify when staff supervisions and appraisals were required. Staff met with their line manager for their formal supervisions and topics discussed included areas of development, wellbeing and issues arising from care provided to people using the service. We reviewed records and the provider's IT system and saw that not all staff had received regular supervision or annual appraisal sessions. One staff member had last had a supervision session in September 2016 while another was recorded at July 2016. One newer member of care staff who had started in January 2017 had no support sessions recorded. The provider admitted they were aware of this and told us that they were working to address these shortfalls.

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

One person told us that care staff were effective in meeting their individual needs and said, "My personal carer now is much more effective than my previous one. She stays in touch with the medical specialist to ensure I get the medication that's right for me."

Other comments included, "These carers seem very independent and know what they are doing and I have confidence in them"; "They are very good, I have no complaints whatsoever" and "My carer is excellent. She really cares and takes pride in what she does. For example she takes the entire burden off me when keeping the house clean and maintained. I cannot bend down myself, so my carer cleans all the cupboards in the kitchen and inside the microwave for me. She deserves more money than she gets for her work."

Care staff supported some people as part of their package of care by preparing meals and refreshments for them. Some people required drinks and snacks to be left within easy reach once the care staff had completed their care tasks and left. Staff maintained daily records which noted what meals and drinks had been prepared and eaten. Where people were at risk of malnutrition, more detailed records were kept. People we spoke with felt that staff provided them with suitable support with their nutritional requirements.

People had been supported to see health and social care professionals when they needed to. People's care records showed health and social care professionals were involved in people's individual care on an on-going and timely basis. We reviewed one person's care plan and daily notes and saw staff had contacted the local district nurse team on behalf of the person when they recognised discharge from a wound. We saw staff had also contacted GPs, hospital outpatient appointments and occupational therapists on behalf of people when this was required. One person told us, "I would not know what to do without them. They have called the doctor a number of times for me."

Requires Improvement

Our findings

All of the people and relatives we spoke with, felt care staff were extremely caring.

However, we explored the provider's caring approach and considered the timescales where actions had been required, both currently and historically and deemed they had not acted swiftly to ensure that people were provided with the best possible care they could be. For example, not having robust quality assurance systems in place for some time, which would have found the issues we uncovered during our review of medicines in people's homes. Also not ensuring that staff followed the principal's of the Mental Capacity Act when supporting people who may have lacked capacity, including when making best interests decisions. Or having care records in place which were out of date, including where one person's husband was still recorded as alive, when in fact they had passed away. This lack of up to date information could have led to unnecessary distress if an unfamiliar carer had referenced this information.

All of the people and relatives we contacted said they had no problems with care staff. They said they were happy with the care received and felt care staff were caring and kind and many went that extra mile to support them. Comments included, "They are wonderful help, and they are what keeps me going"; "I've been getting help from them for a long time. It's good, very good"; "I've got three good girls who visit me. The staff are excellent"; "The girl who comes on the weekend. She is very polite and so caring. She's lovely"; "Sometimes carers and staff change hands, but still maintain good standards in the care I receive – I can't compare one with another, they are all good and kind hearted to me"; "Her [care staff] sympathetic approach has improved my wellbeing and I am very grateful for that" and "They aren't clock watching. They will never say I have to go now in the middle of something."

One person explained the good relationship they had with their care staff and said, "With my Alzheimer's it's very difficult to understand, but the carer that sees me has had very comprehensive training to realise my condition". They added, "The carer also has a very good relationship with my family and it helps me to understand and survive". Another person gave us an example of the caring attitude of staff and said, "I get very frustrated about losing my independence, but my carer understands how I feel and sees me through this over regular conversations."

Only one person gave us an example of a member of staff which they had not "got on with" and they told us, "She's not on the rota now. All of the other carers do everything as they should." They went on to tell us that the provider had removed this staff member from the person's rota once the issue had been raised with them.

Staff we spoke with demonstrated commitment to providing kind and compassionate care. One member of care staff said, "It's important to spend time talking to them [people using the service]. We can talk when we want, but some of the people I visit don't see anyone other than us [care staff] from this day to the next." Another member of care staff said, "I go that extra mile and I don't mind. Sometimes I stay longer than I should but I could not leave someone wanting." A third member of staff said, "Sometimes we are the only people they see. If I am having a bad day, I would never show it…how would you like seeing a miserable carer coming to look after you. I do my best with everyone I visit."

Each person we spoke with confirmed that their dignity was maintained. One person told us, "I feel very comfortable and protected." We asked another person who received intimate personal care how they felt. They told us, "When they [care staff] first started to come to help me, I have to admit, I was a bit uncomfortable. That was not because of the staff, that was just me. They went out of their way to make me feel at ease. Now, they still make me feel comfortable but I have got so used to them and I am fine. They are very good like that. I think they all realise what it's like and act properly."

People told us they received information about the service provided; however, not everyone we visited had a service user guide in their home folders, and when asked, could not recall having one elsewhere. At a team meeting we attended, staff were informed that people's home folders would be all updated to ensure that all relevant paperwork was included for people's information and to support staff. During our visit, telephone calls were answered promptly at the office and there appeared a good rapport with people and their relatives with whom office staff spoke to on the telephone. People and relatives told us that they were involved in their care and had been asked how they wanted support provided. However, this was not always demonstrated in records.

Requires Improvement

Our findings

At our last inspection in November 2016 we found a continued breach of regulation 17 in relation to good governance which included people's records being inaccurate or incomplete. Following that inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we found that the provider had updated their paperwork with regard to people's care. Although some records had been updated and reviewed, we found this had not been applied consistently.

People had an assessment of their care needs carried out by a member of the management team when they started using the service. Once people started using the service a 'care and support plan with service user preferences' was put in place. Care plans are a tool used to inform and direct staff about people's health and social care needs. The care plans we reviewed were not always up to date or fully detailed.

Information about people's preferences regarding their care and support and when it was delivered was not always being followed. One person we visited had care preferences from 2013 and 2016 in place, which could have been confusing for staff as to which one to follow. A review had taken place with them and their family in the last few days and staff had brought the updated paperwork on the day of our visit to the person's home. We saw that they had last received a review of their care in September 2016 so this was not in line with the six monthly reviews we had been told took place. On this person's preferences, they had asked that the morning care call be no earlier than 9:15am, however staff had arrived at 8am on the morning of our visit.

The provider was not always responsive to the needs of people they cared for. When we visited one person their stockings were not applied by some care staff and this limited their mobility. We saw information recorded which stated that particular staff were not able to perform this task, although the staff member had still been sent out to support this person. We discussed this with the nominated individual and they confirmed that this no longer was the case.

The care records of one person we visited were out of date, with details of their husband still recorded as being alive, when in fact they had passed away two years ago. Another person we visited stated on their care records that they were prompted to take their medicines, when in fact staff administered them as we saw this occurring. In another person's care records it stated they liked to have a shower on a particular day but did not detail the person centred way they would like this to take place.

We discussed the lack of information in care plans with the provider. They acknowledged care plans were still in need of updating in some cases. We were told that now the new manager was in place work would be completed to fully review people's care plans to ensure they contained sufficient information to support staff.

There had been one written complaint which had been received since our last inspection and this had been dealt with in line with complaint policy timeframes. However, there were a further 80 complaints logged on the provider's IT system between 5 November 2016 and 31 May 2017; which we could not be assured had been dealt with effectively as the outcome or lessons learnt section was not always completed. People we spoke with told us that any issues they had raised had been dealt with, although we could not confirm this from the records seen.

Three missed calls had been logged as complaints and due to issues with the providers 'Carefree' IT system, we could not be assured that the number of complaints was correct.

These were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

At the staff meeting we attended, care staff were reminded of the importance of completing people's records with accurate and appropriate comments. Staff were reminded that a new signing sheet was either in place or going to be in place in every person's care file so that staff could record their signatures. It was explained this was to aid in the identification of staff signatures on people's records in case of query. It is also important for the provider to be able to identify staff signatures for any investigations that may be required, by the coroner for example.

People who used the service told us they felt comfortable to raise any concerns. Relatives felt the same. One person who had raised a concern about a staff member was asked, "Do you think they [provider] responded well to your complaint?" The person replied, "Yes. It weighed on my mind that she would be visiting. It's much better now." Another person told us, "I have no complaints with either of the two carers that visit me daily. I get on well with them and the two carers get on well with each other. I've been approached to give feedback on the caring I'm receiving, but I've had no necessity to complain."

Other comments included, "They are all alright. I have no complaints"; "Never made a complaint – They've been coming that long I would have called up if I had any problems" and "[Staff name] made a complaint for me about other staff as I'd mentioned to [staff member] that they were rude. I feel comfortable with the staff who visit now. They are always polite."

People we spoke with felt their care and support needs were met by care staff. People felt this was because staff knew people's needs, and information was shared verbally between people, their relatives and staff. Comments from people included, "Well I have to say - I would give my carer 10 out of 10 for her quick response to any of my requests. This includes any food I want and my daily newspaper. My carer asks me very regular if I'm ok, but even more than is necessary"; "I had to go into hospital for a few days in March and my carer made sure I had all the things I needed using a check list. I was so impressed with how organized she was" and "I had a bad fall once in the past, but I still feel very independent apart from being partially sighted and my carer spends a lot of time with me and makes sure I'm stable and ok."

Inadequate

Our findings

At our last inspection in November 2016 we found a continued breach of regulation 17 in relation to good governance which included quality assurance systems not being robust, poor monitoring of risk and out of date policies and procedures. The provider did not always maintain up to date care records for people or keep them secure at all times and had also failed to check records were completed appropriately by staff. Following that inspection, the provider sent us regular action plans of how they were addressing these concerns.

At this inspection we found continuing breaches, as well as those in regard to regulation 17.

Although the provider had completed some checks and audits their quality monitoring systems were still not adequate. Effective governance systems, such as regular audits, should enable continuous improvement of the service. However, these had not been undertaken effectively. The provider had sent us weekly action plans and reported "Full QA documentation programme will be completed by 31 March 2017. Medication Audit tool is in draft and updated 6 week and 6 monthly service user review documentation drafted and will be rolled out after the update meeting scheduled for 22 March 2017."

The audits which had taken place had not identified that care plans, risk assessments, capacity assessments or best interest decisions were either not in place or did not contain enough detail to guide staff to deliver safe care. Checks had also not identified the issues which we had found with the safe administration of medicines in people's homes.

Spot checks and observations were being carried out, but these had not identified the issues we had found during the inspection. Staff training records did not give an accurate overview of training completed by staff. In some cases showing training as completed when it had not been and in other cases not showing training which staff had completed.

There was a board of directors in place which met monthly. We saw minutes of a recent meeting which showed that a report had been presented to the board and gave an update on recruitment, staffing pay structure, premises issues, branding of the business and the monitoring system.

Improvement had been made to recorded information available which had been discussed at board level. However, there was no evidence presented to illustrate that quality management information, for example, audit reports, risk management reports or assurance information was being presented and discussed at

board level. This meant it was difficult for the board to have a full overview of the running of the service.

We were also informed that senior managers met periodically to discuss the service provision, however, these meetings were not recorded and we could therefore see no minutes to evidence the discussions that took place or any subsequent actions or ideas for improvement.

No survey had been undertaken since our inspection in February 2016. The provider had returned a Provider Information Return (PIR) in May 2017. They reported that they intended to introduce "service user and family survey to be completed annually" and to "development an ongoing survey of our staff annually", however, this had not occurred.

We found some policies and procedures had been updated but not all of those required. The provider confirmed that further policies were due for review. Policies and procedures were in place but some were either not fully detailed or not up to date and this meant staff may not have had access to up to date information to support them. For example, the policy on 'Accident reporting February 2010' contained information which was confusing. It highlighted a number of different routes for reporting; two different accident/incident forms were seen with also reference to an accident book. A new draft policy was in progress which we were told should have been completed 31 March 2017, but this was still not completed. The medicine policy had not been updated in line with NICE guidelines published in March 2017.

At the last inspection we were able to find archived records. At this inspection we were unable to find some of the older records we required, for example archived medicine administration records for some people. Staff told us that they intended to put in place a new system for storing older records but this had not been started yet.

We asked for a log of missed calls between January and June 2017 and were provided with a list showing 22 missed calls logged on the provider's IT system. It was explained to us by one of the schedulers that the list may not be correct as some of the calls may not have been logged correctly. We were also aware that a number of logged complaints were in fact missed calls. It was therefore difficult to establish exactly how many missed calls there had been over the period of time reviewed. When we reviewed other information on the providers IT system we found incomplete records and incorrectly recorded information. For example, a staff member had called at one person's home to support them with their care needs. The person was not at home as they were still in hospital. This was recorded as a missed call, when in fact in was not.

Monitoring of risk remained inadequate. Accident and incident recording on the provider IT system was not robust, with outcomes and lessons learnt not always completed. No evidence was provided by senior staff to demonstrate that investigation or the cause of accidents and incidents and the sharing of information across the service was completed. We were told by the nominated individual that checks on the providers IT system was completed every month to monitor accidents and incidents which had occurred. However, we saw no evidence this was recorded, with lessons learnt and outcomes of accidents not always completed either.

These were an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager in place, but a newly appointed manager had taken up their position in the last few weeks and confirmed an application was going to be submitted once their DBS check had been returned. There was a nominated individual who worked out of the office and they were supported by the managing director who came into post in November 2016.

Since our last inspection in November 2016, we saw that the provider had implemented longer office opening hours from Monday to Friday from 8am until 8pm which meant that office staff were available additional hours to provide direct support to staff and people using the service when required. One person said this was positive and told us, "Recently the hours of access to the office has increased. It mean's I can call them if I need to feedback anything." People who used the service and care staff continued to be supported by an on-call out of hour's system. This provided advice, support and guidance outside of office hours when necessary. Care staff said their calls were responded to quickly.

We asked people and their relatives if they thought the service was well led. One person told us, "In my view [the service] is not being as well led as it used to be. I think they are cutting back on recruiting staff from every two to one person." As we found in the safe domain, we found no evidence to suggest this was the case with regards to recruitment. Another person told us, "I've seen improvements over the years. I think they are getting more business-like and professional." A third person told us, "I've seen a distinct improvement recently. Originally the care was not to the level it is now."

At our last inspection staff drop in sessions had taken place on a regular basis and senior care staff worked in the community with care staff. However, with changes to management, over half the staff we spoke with felt not as supported as they had previously been. The new manager of the service had recently introduced more formal monthly meetings which focussed on best practice and offered the opportunity for additional support to care staff. Many staff recognised that changes were needed, with others preferring the old way of working. One staff member told us, "Things had to change but the transition could have been planned better." Another staff member said, "Communication is improving slowly." The new manager had introduced short daily 'flash' meetings with staff in the office. This was a new way of discussing any issues arising and deciding on allocation of work for the day. During our inspection we noticed that the office environment was much calmer than at the previous inspections. We saw the new manager supporting staff throughout our visit and offering additional guidance to a member of staff on a matter which they had raised.

The new management team were working on promoting an open culture at the service. The managing director sent a monthly team brief to the whole staff team. This included changes to organisational procedures, new appointments, new positions, discussions around training and updates on regulatory compliance. New monthly meetings for care staff had been set up and staff were expected to attend and contribute towards the agenda. One staff member told us, "They [new management] have made lots of changes; it's a case of getting used to them. Some staff are long in the tooth and are finding it hard to change, but they need to."

The provider was meeting their legal obligations with regard to submitting statutory notifications to the Commission. A notification is information about important events or incidents which the provider is required to tell us about by law. They notified the Commission as required and provided additional information promptly when requested and working in line with their registration.