Ms Andrea Mckie

Angels Assisted Living Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced focussed inspection of this service in November 2016 after the provider had been issued with a warning notice in relation to good governance in December 2015. We found the provider had met the requirements of the warning notice. At the inspection in December 2015 the service was also in breach of a further two regulations in respect of safe care and treatment and staffing.

This announced inspection took place on 7, 9, 12 and 19 June 2017.

Angels Assisted Living Services is a Domiciliary Care Service which is registered to provide personal care to people in their own homes. At the time of our inspection the service was providing care to five people all of whom were living within the housing complex in Prudhoe. The service also provided emergency response cover to all of the people who lived in the housing complex at Prudhoe and also a similar housing complex in Alnwick.

Under its registration with the Care Quality Commission (CQC) this service does not require a registered manager, as the provider of the service is an individual in day to day charge of operations. 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 had recently received a number of safeguarding concerns in relation to the provider and the service offered to people they supported. These are currently being investigated by the local authority safeguarding team and we will continue to liaise with them and take further action if found necessary to ensure the safety of people.

We received mixed views from people and relatives during our inspection. We found that there had been historic blurring of the roles and responsibilities between the management of Angels Assisted Living Services and the previous manager within the housing complex in which the provider worked in Prudhoe. This had caused confusion for people, relatives, staff and visitors as to whom they should refer to when a care issue arose.

There had also been issues in connection with the level of care to be provided, particularly the emergency response element of the service with comments made indicating they thought there was not enough staff. At the time of the inspection the records reviewed and the providers explanation suggested there was sufficient staff.

Staff understood their responsibilities of reporting any allegations of abuse and knew how to raise concerns if needed. People were supported to have their prescribed medication safely.

The provider had not always acted safely, swiftly or appropriately in relation to recruitment procedures, employment checks and investigations completed with staff. This meant staff may have been employed, or

employed longer than they should have, who were not suitable to work with vulnerable adults.

People's safety was protected because risks assessments identified risks that were specific to their needs and care plans were individualised. However, the provider had no pre-assessment information available and told us they destroyed this information once they had drawn up care plans. People and their families told us they had been involved in formulating people's care plans.

The provider's business continuity plan needed to be finalised to ensure that if the service had an emergency, they would be able to carry on providing care to people safely.

Staff felt supported and they received supervision sessions and annual appraisals, although they were not always recorded. Training was provided and induction was based around the Care Certificate standards.

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 received suitable food and refreshments which met their needs. People had access to healthcare professionals although not all comments received from people or relatives felt this was the case. This is being separately investigated currently by the local authority safeguarding team.

We received mixed views about the caring nature of the service and its staff, including the provider. Surveys had been sent out to gather the views of people and the majority of those returned had been positive. People and their families told us they knew how to complain if they felt they needed to.

Activities were made available to people if this was part of their care plan, including those which were facilitated in the complex in which they lived.

Communication between the provider and other agencies or services was not as good as it should have been. We found that roles had not always been clear and this included who people, relatives or staff should speak with regarding issues arising.

The provider had not always followed their own policies and procedures, including those in connection with gifts.

Quality monitoring systems were in place and when issues had been identified, actions were put in place to rectify these. Although not all the issues we had found during our inspection had been identified.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the good governance and fit and proper person's employed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected from the risk of abuse because the provider had not always followed safe recruitment and investigations processes.

Staff had received safeguarding training and knew how to report any form of abuse.

A number of concerns had been raised and these were currently being investigated by the local authority safeguarding team.

People were protected against the risks specific to their individual needs because staff had the information they required.

People were supported by sufficient numbers of staff and received their medicines appropriately.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received the training they needed to do their job effectively.

People received enough food and drink and were supported to have food that they enjoyed.

Staff received support but this was not always formally recorded.

People were supported to maintain good health and to have access to other health and social care agencies when required. Although not everyone thought this.

Is the service caring?

Requires Improvement

The service was not always caring.

We received mixed views from people and their relatives about whether they were treated with kindness, dignity and respect by

staff.

People were encouraged to express their own views, preferences and opinions. However, relatives told us they had not been asked to complete any feedback on their views.

People were supported to remain as independent as possible and although no one currently used advocacy services, the provider knew how to access this type of service if it was required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person-centred and reviewed regularly. However, the provider had not kept pre-assessment documentation.

People and their families knew how to make a complaint if they were unhappy. However, some relatives felt verbal complaints were not acted on or recorded as complaints.

People received a choice in what they wanted to do and had a range of activities they could participate in if they wanted and had been agreed as part of their care plan.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We saw improvements had been made to monitor the quality and safety of the service at our last inspection. However, further improvements were now required.

Policies and procedures were not always followed fully.

We found confusion had occurred over the leadership of the care element of the service in connection with people, their families and friends.

The provider had sent us notifications in line with their legal requirements.

Angels Assisted Living Services

Detailed findings

Background to this inspection

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

This inspection took place on 7, 9, 12 and 19 June 2017 and was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be available at the provider's offices and also to allow the provider to notify people that we were undertaking an inspection.

The inspection team comprised of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we looked at previous inspection reports and checked the information that we held about the service. This included notifications from the provider they are required to send us by law, including safeguarding concerns or incidents involving the police.

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 received feedback from external agencies and other health and social care professionals who were familiar with the service. Including the local authority commissioners and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

During our inspection we spoke with all five people who received care and support from the provider in the Prudhoe housing complex and also four people's relatives and two friends. We spoke with seven people who lived in the housing complexes and who were entitled to use the emergency responder element of the service. We also spoke with three care staff from another agency who were visiting the housing complex in Prudhoe during the inspection and provided care to the some of the same people whom the provider's staff supported.

We spoke with the registered provider, the administrator and communicated with seven staff (including those currently employed and those no longer employed by the provider). We also spoke with two care managers from the local authority, one occupational therapist, a specialist in Motor Neurone Disease and a district nurse.

We looked at the care and medicines records of three people and reviewed the records of four members of staff. We also reviewed records in connection with the management of the service, including audits of medicines, training records, surveys and staff meetings.

Requires Improvement

Is the service safe?

Our findings

At our inspection in December 2015 we identified a breach of regulation 12 (Safe care and treatment). Risks were not always identified and risk assessments were not always fully completed. We also identified concerns with medicines management and administration.

The provider sent us an action plan to show us how they would address these shortfalls. At this inspection we have found the requirements of regulation 12 are now being met.

The provider told us they normally applied for DBS first checks when new staff were appointed and then allowed staff to start work under supervision, or while they completed training as they waited for their full DBS check to be completed. There had been a recent issue with this procedure which had meant a staff member appointed had concerns raised on their full DBS which the provider was unaware of on appointment. The provider had not acted as swiftly as they should have once they realised that the full DBS was not as expected. This meant the provider had not taken all the precautions they could have, to ensure they had employed staff of good character and fit to care for vulnerable people. The provider told us that they were going to change their procedures and only allow staff to start work once a full and suitable DBS check had been received.

When we reviewed investigations that had been completed by the provider, we found they had not always followed the process to a conclusion. For example, a member of staff had left the employ of the organisation before a final decision had been concluded in respect of an investigation which had been conducted. Although people were not as risk because the staff member had left employment, the staff member ended their employment with a blemish free record when this may not have been the case. It also meant that any potential referrals to the DBS had not been made.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to fit and proper persons employed.

Staff recruitment files we viewed and all of the staff we spoke with confirmed that the provider's recruitment processes included a formal interview, and obtaining two references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable applicants from working with vulnerable people who require care. One member of staff said, "I heard about the job. I had to fill in an application form. I then went for an interview and then done training and shadowing before I started working properly." They also said, "Yes, they asked for references and I had a DBS check."

One relative told us, "It's gone a bit haywire – they [provider] are unable to fill vacancies and have re-employed previously sacked staff." We discussed this comment with the provider and found no evidence to suggest this was the case. All staff had received references from previous employers and staff archived records confirmed no member of staff had been previously 'sacked' and then re-employed.

Multiple safeguarding concerns had been received in connection with the service and its staff from a variety

of sources. This included people or families of those who used the service, friends and ex staff members. At the time of our inspection the local authority safeguarding team were undertaking a thorough investigation into all of the recent allegations. We cannot report on these investigations at the time of the inspection. However, the Commission will monitor the outcome of the investigations and actions the provider takes to keep people safe.

Records we looked at showed that staff had received training on how to keep people safe from avoidable harm and abuse. All staff were in the process of receiving further updates to this training, this work was ongoing. The provider told us that the safety of people using the service was a priority and they wanted to ensure that staff felt confident to deal with any risk issues such as safeguarding if they were to arise. When asked, staff were able to tell us what procedures they would follow if they suspected any form of abuse had occurred. One member of staff told us, "We have had training on it [safeguarding]; it's about knowing when something is wrong and reporting it. Would report anything like that."

The majority of people we spoke with told us they felt safe. Comments included, "Feel safe, would never say I am not safe"; "Yes, I am safe here and the staff look after me well"; Safe, yes I am"; "No reason not to be safe" and "Not sure what you mean, of course [feels safe]." However not everyone we spoke with felt that people were safe. One relative told us, "They [provider] do not make sure that [person] receives the right care at the right time." They gave us examples of occasions when care had not been provided fully. Healthcare professionals we spoke with told us they felt people who received care were safe. One said, "They [care staff] try their best in sometimes difficult circumstances. There has been a range of problems recently. Not all to do with the staff at Angels I have to say. I am sure that people are safe….yes." From our inspection we found no evidence to suggest the care received (or lack of) made people unsafe.

Some of the people we spoke with told us they required help with the administration of their medicines. One person told us, "They [staff] help me with my tablets." Another person said, "I cannot do my own medicine but the girls here help me." We observed one person receiving their medicines and staff completed the process correctly and in line with best practice, paying attention to the person and ensuring they knew what was taking place and were in agreement. When we asked relatives if medicines were administered safely, they told us, "I can only assume they do [administer them correctly]" and "I think so, it's difficult for me to say – I don't live there."

We checked medicines records and found the majority of people received their medicine in packs made up by the chemist, although some did receive individual boxes for separately prescribed medicines. The MARs we checked had all been filled in correctly with people's prescribed medicines with no missing gaps. We could see staff had signed to say medicine had been administered. Staff ensured people's medicines were stored safely and discarded after 'use by' dates had been reached. We noticed one person had a particular medicine which was required before breakfast; this information was not recorded on the MAR. We brought this to the attention of the provider who contacted the pharmacy and had this adjusted with the medicine also now being dispensed separately to the dosette box. Monitored dosage systems (dosette box) are a system used by pharmacists to dispense medicines so that people can keep track of what to take at particular times of day. They are usually in some form of tray with medicines boxed into individual pods which are labelled by day and time.

Staff said their medicines training was up to date and records confirmed this. We also reviewed staff competency assessments (spot checks) to confirm staff were suitable to administer medicines to people.

People's care records detailed information on 'how people took their medicine'; including information on allergies. Information was also available to staff on more 'risky' medicines through information leaflets and

medicines profiles completed. One person preferred to apply their own topical cream, but this had not been included on their medicines risk assessment. We confirmed that there had been no issues in connection with this and staff had ensured creams had been applied as prescribed. We were told that medicines risk assessments were in the process of being updated and the provider said they would update the medicines risk assessment for the person who self-administered their own 'creams'.

A medicines profile was in place for each person. It listed the medicines people were currently prescribed with a description, any adverse reactions, times to take and reason for taking. All of this information supported staff to ensure that medicines were administered as prescribed. There was also a list of medicines which was recorded separately and would be given to the emergency services should, for example, a visit to hospital be required. We found that the emergency list did not always match with the medicines profile. We discussed this with the provider and they told us they would incorporate both forms into one on the medicines profile.

Patch application charts and body maps were used to support staff in ensuring that medicines were applied in the correct position. Patch application charts and body maps are pictorial documents used in conjunction with written information to record the location of where medicines should be applied. This meant that staff were less likely to administer medicines incorrectly.

The medicines policy was in need of review in light of the recent National Institute for Health and Care Excellence (NICE) guidance published in March 2017 in relation to medicines management in domiciliary care services and the provider said they would update their policy to ensure they continued to follow best practice.

The majority of people we spoke with told us there were enough care staff, they were reliable and usually on time. However not everyone we spoke with felt the same and told us that on occasions staff did not attend as they should. Comments included, "They [care staff] are often late"; "Don't arrive at the agreed time – don't provide the full time allocated" and "There should be two staff on duty during the night…what if something happens? One person cannot deal with two people, can they?" We checked the register of responses the provider had recorded and saw that a range of people had used the emergency response system with a variety of staff responding to them. The emergency responder element of the service was funded by the housing provider who had agreed to one staff member overnight. This was backed up by a telephone monitoring services that could be called upon if additional support was required.

We received an allegation that the correct number of staff were not always available to support people with their moving and handling requirements. We spoke with an occupational therapist involved with the service and they confirmed the correct levels of staff were available, which in some cases was only one person rather than the two staff alleged to have been required at all times for some people.

We reviewed processes and information received and confirmed that the provider had enough staff on duty for the contract they had been given.

We found the provider had reviewed and identified potential risks to people's health and well-being and that these had been formalised into risk assessments which were held within people's care records. These included those in relation to moving and handling, falls, behaviours which challenge the service and those more general risks in relation to fire or pets. The provider had also risk assessed any potential hazards regarding staff working at the service. During the inspection the provider put in place an updated diabetes risk assessment for one person. They completed this together with a healthcare professional to ensure that staff had up to date information and that risk had been mitigated as much as possible.

There had been no recent accidents recorded but historic recordings showed that they had been recorded and dealt with appropriately. The provider also monitored these for trends forming.

The provider had a business continuity plan in place but it was not completed to fully protect people should the need arise from an emergency. For example, if staff were unable to provide care to people at the service due to extreme weather conditions which stopped them from attending people's homes. There had been no need to implement the plan, but without it fully in place, the provider ran the risk of not being prepared should the need arise in the future. We spoke with the provider about this and they said they would have it updated straightaway.

Good

Is the service effective?

Our findings

At the last comprehensive inspection in December 2015 the service was in breach of regulation 18 in respect of staffing. Staff were not sufficiently monitored before being assessed as competent.

The provider sent us an action plan to show us how they would address these shortfalls. At this inspection we found the provider was now meeting regulation 18.

Supervisions and yearly appraisals had been completed with staff but supervisions had not been always formally recorded as per the provider's policy of two monthly. Staff told us they felt supported and said, "We are a small team and based in the same office. We speak to [provider's name] all the time if there is anything we need to talk about." Conversations were seen to take place on a daily basis with the provider who tended to split her time between the two housing complexes in Prudhoe and Alnwick.

The majority of people we spoke with told us that the staff who visited them seemed to have the knowledge and skills they needed to meet their needs. One person told us, "They seem to know what they are doing." Another person said, "They [staff] are good at their jobs." However, one relative told us, "Don't have people skills [referring to some staff and the registered provider], but yes to other skills."

Newly employed staff at the service completed their induction based around the standards of the Care Certificate. We reviewed evidence of this in one fairly new staff members training record. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards.

Staff we spoke with told us they felt confident in doing their job and confirmed they received sufficient training. One member of staff told us, "Training is good; we have refreshers every so often." Another member of staff said, "We do quite a bit of training; I started new to care but have learnt so so much."

The provider had a record of the training that staff had completed and this showed that staff had received the training the provider deemed required to meet people's needs, with refresher training planned to take place. Staff we spoke with told us they were encouraged to attend training.

Staff meetings were held. Staff we spoke with told us that these meetings, together with supervision and easy access to the management team, meant that they felt supported in their roles. We found that staff could access help and advice either by contacting the office or speaking with the provider when they were covering shifts. One member of staff told us, "I feel very supported, I can speak to [providers name] anytime about anything." Another member of staff said, "I have never had a problem with getting support when I need it."

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.

We saw assessments of people's capacity had been carried out by the local authority and where a best interests decision had been made, records confirmed this had been completed in line with the requirements of The Mental Capacity Act 2005. People we spoke to told us that care was provided to them with their consent and we observed this in practice throughout the inspection as staff asked people their permission before embarking on particular tasks. People had also signed consent to share information and to also confirm they had been involved in the planning of their care. The provider also told us that they were in the process of updating to a new capacity assessment tool which would be used in the future to establish if people were deemed to have capacity or not.

We found that people were supported to have sufficient to eat and drink and were given choices. There was a restaurant within the housing complex which people were welcome to visit to purchase meals during the day. We observed staff supporting three people to attend the dining area and participate in meal time experiences. One person told us, "She [care staff] always makes me things I like." Another person said, "They [care staff] leave drinks for when they are not here". Relatives told us, "They [person] are taken to the dining room area or they eat in their flat"; "Drinks…yes. Meals eaten in the Café" and "It has got a lot better." Staff were aware of people's likes, dislikes and preferences and those we spoke with told us how important it was to offer choice around meal times.

The majority of people we spoke with told us that staff supported them if they were feeling physically unwell. This was for the service overall, including the emergency responder element. One person said, "They [care staff] are here to ring (and showed us the call bell) if you have a problem and need help. They would come and check you're okay and see if you needed assistance." Another person told us, "I have rung them before. They got the doctor out for me….it was a while ago though."

We reviewed records of calls made to the responder service since our last inspection and found a variety of calls and responses made to various people who lived in the housing complex, including privately paying people and those funded through the local authority for their care. Not everyone used the responder service and two people we spoke with confirmed this. They said they did not feel the need to use it. We found no evidence to suggest that people were not supported to access healthcare services when the need arose. We saw evidence in records that people had attended GP, audiology, diabetes clinics and other hospital appointments. Other healthcare professionals had been involved, including specialist nurses and the Speech and Language Therapy team (SaLT). One healthcare professional told us, "On the whole, the service responds well." Two other healthcare professional seconded these views.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people, relatives and others involved with people who received support from the provider, regarding whether the service was caring. Positive comments included, "There is a reason they are called Angels – because they are"; "They [care staff] are good"; "Yes, they [care staff] are canny [kind]" and "Definitely [caring] - one carer is very kind and considerate and an older male carer always has a good laugh." Negative comments included, "They occasionally get care staff with good hearts, kind and caring, professional people….but they [provider] don't listen"; "[The provider] is nice as nice to your face when there are people around but not so when your alone with her"; "[The provider] is not caring, she only cares about money" and "They [the provider] have got rid of them now, but one [member of care staff] was horrible. They should never have been allowed to work in care." We found no evidence to substantiate the negative claims, although as part of the investigation being undertaken by the local authority safeguarding team any concerns will be looked at.

We discussed our mixed comments which we had received with the provider. They said they could not understand why "people were saying those things", but acknowledged that there had been some issues which they felt had been addressed. They said, "I have always cared about the people I look after and this upsets me to hear that people are saying that about me." They went on to say, "I hope the safeguarding investigation shows the service as good." They went on to explain that they would work with other healthcare professionals to complete any actions if required or address any worries that people might have after the safeguarding investigation was completed.

One person told us, "A particular carer was rude and disrespectful." The provider had dealt with this appropriately through their normal policies and procedures.

One healthcare professional told us (in relation to one particular person provided care by the provider), "Angel's staff are wonderful and go out of their way to support this person." Another healthcare professional told us, "I think there have been issues in the past, but now staff seem caring."

We overheard three people who lived in the housing complex in Prudhoe talking about care staff. One said, "There nice lasses." Another said, "Aye [yes] they are canny [kind]."

People were encouraged to express their own views, preferences and opinions. Surveys had been recently sent out to all of the people who lived at the housing complex in Prudhoe. Out of 17 surveys returned 13 were positive, one was neither positive nor negative and two raised concerns, one in relation to an ex member of staff. The final survey was clearly completed by a member of staff from a service involved with the housing complex, although no names were given. They commented that communication was not good and that the provider involved themselves in issues that were not their concern. The provider had seen this feedback but had been unable to act upon it due to the safeguarding investigation taking place.

When we asked family members about expressing their views, their comments included, "You are the first person to have asked me of my opinion of the service"; "Questionnaire - Not really" and "Never."

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in connection with good governance.

From our observations during the inspection we saw appropriate and caring interactions taking place. Staff explained to people what they were going to do. For example, while giving medicines or when about to complete a personal care task with them. We observed staff bending down as they talked to people, so they were at eye level as maintaining eye contact helps enhance effective communication.

People were supported to remain as independent as possible. One person told us, "I like getting out. I sit at the front... I go to the shops." We observed this person both sitting enjoying the fresh air and venturing to the nearby shops during the inspection. Other people were supported to mix with others in the dining and communal areas.

The majority of the people we spoke with said that the staff treated them with dignity and respect. One person said, "Very dignified". A relative we spoke with told us that the care staff were polite and friendly and very respectful.

Staff we spoke with told they were mindful of protecting people's privacy by closing and shutting doors when they provided personal care to people and that they respected people's privacy at all times. We observed this in practice when we visited one person who asked for staff to help them with a personal care matter. From our observations staff treated people with dignity. However, not everyone we spoke with thought that dignity was maintained and one relative said, "Certainly not (meaning dignity was not maintained)." These allegations were included as part of ongoing investigation being undertaken by the local authority safeguarding team.

No one who used the service had the need to engage advocacy services as they had family or friends to act on their behalf. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The provider was aware of services in the local area and how they could be contacted if people did require additional support.

Requires Improvement

Is the service responsive?

Our findings

The provider had not always kept copies of their pre-assessment information, which is information gathered prior to a person being accepted into the service. The provider told us, "I normally type up care plans from the information I get during a visit and just destroy the notes I have made." Keeping pre-assessment information is particularly important with regard to private paying people where the service may not have received any details and history from the local authority. These documents can be used to track for example, that pre-existing health needs are being met by the provider.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in connection with good governance.

People we spoke with and their relatives, friends and others involved with service gave us mixed views on the responsiveness of the service. Most people told us they thought staff responded well and met their needs. One relative said the provider had responded well to a concern with the changing needs of their relative and said, "My father wanders at night which has caused concerns so the manager has arranged for nightly checks." One ex staff member who contacted us, "They [provider] don't respond well. People are sometimes left because we are told to leave them until the other care staff come on duty (another care provider). We found no evidence to support this during our inspection, although this allegation is part of the investigation by the local authority safeguarding team.

Other comments from relatives included, "They take note of peoples' needs and carry out a service to the best of their abilities"; "Seems to be pretty well looked after"; "I am satisfied"; "Having the staff on duty overnight is good" and "Overall – based on the past year it has been pretty bad." This last comment was based on changes within the housing complex and also changes within the provider's staff team, including allegations made regarding care. These allegation forms part of the investigation being undertaken by the local authority safeguarding team.

People we spoke with told us that they knew how to complain. Relatives also knew who they needed to contact with any complaints or concerns, although one told us they were not always listened to or verbal complaints acted on. One relative told us, "Complained to the manager about verbal abuse by a carer and carer was removed immediately." There had been no formal complaints recorded since our last inspection and any historic complaints had been dealt with appropriately.

We saw care plans acknowledged people's preferences and people were referred to by their preferred name. Care plans which were drawn up by the provider in response to people's assessed need, described what support was required. For example, one care plan was very detailed in how one person was to be supported with eating and drinking. This care plan had been drawn up with the support of the Speech and Language Therapy Team and was used to ensure the person's needs could be fully met. Another care plan in relation to a person who was hard of hearing clearly stated how staff should support them by speaking clearly and facing the person for example. All relevant information was contained within care plans, but we noticed some information was sometimes duplicated. For example, we saw a care plan for the same person for

'hearing' and another for 'communication' and the information contained within them both was similar and included for instance, 'speaking clearly'.

One person who was deemed to have capacity and who was at risk of choking preferred to eat food not recommended by healthcare professionals. Health care professionals had been fully involved, including the Speech and Language Therapy team (SaLT). Clear documentation was in place, including the risks associated with this activity and what staff should do in the event of an incident. This showed that people had clear choices even when it went against professional advice and we saw staff respected those choices.

Activities took place within the housing complex and we were told by one member of staff that people could attend anything they wanted to. We were told by the same staff member that one person enjoyed playing bingo, while another sometimes liked the other entertainment provided. Staff supported people to be able to participate in activities if that was part of their care plan. Two visitors we spoke with told us, "Activities are always taking place. Staff (provider's) help people to attend if they want to."

Care managers from the local authority were involved with the majority of people cared for by the provider. We were aware that various meetings had taken place to ensure that care was being provided to meet people's needs. However, not all parties involved had been happy with the service provided and this formed part of the investigation currently being looked into by the local authority safeguarding team. We continue to monitor this and will take further action if necessary.

Requires Improvement

Is the service well-led?

Our findings

Under its registration with the Care Quality Commission (CQC) this service does not require a registered manager, as the provider of the service is an individual in day to day charge of operations.

A member of staff had received a gift from one of the people using the service. The provider was aware but had not followed their own policy in relation to this. Their policy on 'gifts' stated, 'gifts given to employees by service users must be recorded and monitored as regular gifting can indicate unhealthy dependence'. We saw no evidence to suggest this procedure had been followed. This potentially placed people at risk of abuse.

A range of audits had been undertaken by the provider. These included, for example, those in connection with medicines and care plans. We saw when errors or omissions had been noted that actions were put in place and the provider ensured these were completed. However, these audits and checks had not found the issues we had as part of our inspection. For example, those in connection with omissions in recording of supervision sessions and issues with recruitment procedures.

Supervision sessions with staff had not always been formally recorded, and although staff felt supported there was no evidence to confirm conversation which had taken place. This meant staff records were not accurately maintained at all times.

Staff meetings had been held and staff said they discussed a range of issues. Staff also told us that because they were a small team, conversations often took place in the provider's office where the team were based. Minutes from meetings showed they covered a range of topics including employment issues, updates on the service, and sharing best practice, including medicines. However, meetings were not recorded as held that often, for example, the last full general staff meeting was held in May 2016. We noted that minutes of that meeting indicated an issue with communication and that it was not as good as it should have been. However, current staff provided positive feedback about the management team at the home. The provider told us that they intended to hold more regular meetings and we confirmed one had been booked for the end of June.

We were told by the provider that any relevant information was passed on to other healthcare professionals, including other services working out of the same building and we saw evidence of this. However, communication between the provider and other home care services using the housing complex was not as good as it should have been. We spoke with staff from other organisations who worked in the same building in Prudhoe and with some of the same people whom the provider cared for. They told us, "Communication has deteriorated. It's not very good now at all. It used to be ok but not now" and "We don't always find out what has happened during the night if they [provider] have been called out. That is not very good." We spoke with the provider about communications between services and although they thought it had been good, they agreed in recent times it had deteriorated.

The previous management of the housing complex and the provider's roles had become blurred; people,

their families and other interested parties who may have visited the housing complex (including healthcare professionals and ex staff) had become confused with who was responsible for the care needs of people. Some referring to the provider when others referred to the housing complexes previous manager. This had caused issues in a number of ways and was part of the ongoing investigation that the local authority safeguarding team are undertaking.

We were shown a copy of the contract for the emergency responder service and the provider confirmed it was not fully clear exactly what was required from the provider. The provider told us, "It's always been unclear" During discussions it became clear that the provider did not fully understand their role as they indicated they greet people coming into the building as they pass their office. We asked if that was part of the contract and they said, "That is how blurred it is".

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

We asked people and their relatives/friends and other visitors and care staff to the housing complexes who had some form of contact with the provider, if they thought the service was well led. We received mixed views. Comments included, "I would say so"; "A1 for that"; "Looking after all people – they do everything for them" and "Always available on site." However, some told us, "Service is not well led – it's run to suit the owner and not the residents" and "The relationships have all gone downhill…changes need made and quick."

A number of those we spoke with said that the language used by the provider and the staff team was not appropriate, which included swearing being overheard from the office in which they were based. Comments included, "You can often pass the office and hear them swearing to each other. It's not what you would expect to hear really" and "Swearing was not uncommon." Although we did not observe this ourselves during the inspection we did note that this feedback had been received by more than one person and deemed this as not being professional behaviour or conducive to a good culture within a social care organisation.

Staff we spoke with confirmed that they felt supported in their role through open communication links with the management team via supervision and regular contact with the provider. They also told us they felt comfortable and confident in raising concerns with the provider. One member of staff told us, "They [provider] have been very good to me, I can talk to them about anything". Another staff member said, "Any problems I can just ask."

Spot checks were completed with care staff to ensure they were competent to work with the people they cared for. The provider was in the process of updating their competency spot checks to incorporate medicines and people's views as they were normally added as 'additional comments'.

The provider had ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, about were sent. This included notifications of a safeguarding nature or those in connection with deaths or when the police had been involved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not always maintained records as they should have. Policies and procedures were not always followed and not all risk mitigated. Audits and checks were not always robust as they had not uncovered the issues we had found during our inspection. The provider had not always actively sought the views of relatives, through surveys or questionnaire's. 17 (1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not always followed safe recruitment practices or ensured that staff employed were and continued to be of good character. 19 (1)(a) (2(a)(b))(5)(a)(b)