Nestor Primecare Services Limited

Allied Healthcare Doncaster/Rotherham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This announced inspection took place on 26 and 27 June and 03 July 2018. At the time of our inspection 181 people were receiving support from the service. At our last inspection on 29 March 2017 this service was rated good in all key areas; at this inspection we found the quality of the service had deteriorated and required considerable improvements in particular in the safe domain.

Allied Healthcare Doncaster/Rotherham is a domiciliary care agency. It provides personal care to people living in their own houses, flats and extra care housing in the community. It provides a service to older adults, including people living with dementia, younger disabled adults and children living in the areas of Rotherham, Doncaster, Barnsley and North Lincolnshire. Not everyone using Allied Healthcare Doncaster/Rotherham receives a service which is a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

On the day of our inspection a registered manager was in place. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found six breaches of regulations in relation to safe care and treatment, safeguarding, consent, person centred care, good governance and registration regulations. You can see what action we have asked the registered provider to take at the end of the full version of this report. Overall, we have rated the service as Requires Improvement. This is the first time the service has been rated Requires Improvement.

Most people told us they felt safe using the service. Safeguarding procedures were in place however we found some people using the service were being restricted of their liberty without the appropriate legal authorisations or risk assessments in place. We found the registered provider was not always following their own policy in relation to dealing with missed care visits and some incidents were not being identified as safeguarding concerns. The registered provider was not always informing CQC when safeguarding concerns were being investigated.

The management of risks and care planning was inconsistent. We found some people had very comprehensive and detailed risk assessments and care plans, while other people had very succinct or even non-existent risk assessments.

The registered provider was not always following their own medication policy in relation to the correct management of 'as and when required' medicines. We also found medication audits were not being consistently completed.

We found people who had started the service with end of life needs did not have any assessment of their needs, risks involved in their care or records of care to be provided. The lack of information and guidance could put people at the end of their life at risk of receiving inappropriate care and treatment.

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed.

People's rights under the Mental Capacity Act (2005) were not supported through recorded mental capacity assessments to assess their ability to make decisions about their care and treatment. This is important to ensure people are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible.

People and their relatives told us staff were kind and caring.

People were supported to eat a balanced diet that met their individual dietary needs. They were supported to access healthcare services in order to maintain their health.

Staff were supported through a comprehensive induction, regular supervision and annual appraisals. However, we could not be certain all staff supporting children had the specific training required.

There was a complaint policy and procedure in place but two people told us they had raised concerns to staff and no action had been taken.

Staff told us they felt supported by the management team and people spoke positively about staff.

There were several systems in place to monitor the quality of care; however these were not always effective in identifying the issues found at this inspection.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

We identified safeguarding concerns during this inspection. As and when required medicines and emergency medication were not always managed safely.

The registered provider's approach to risk management was inconsistent. Some risk assessments were very detailed, others were not and we found some people did not have relevant risk assessments.

There were safe recruitment policies and procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not supported through recorded mental capacity assessments to assess their ability to make decisions about their care and treatment.

There was a comprehensive induction and training programme, but we could not be sure all staff supporting children had their training up to date.

People were supported to eat a balanced diet that met their needs and access other healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knew how to promote people's privacy and dignity, but we found examples of people being supported with personal care by staff of a gender that was not their preference.

People told us they were supported by regular staff and they had positive relationships with them.

Some care plans did not include information about people's

personal preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered provider was not always assessing people's needs prior to commencement of the service.

We found inconsistent quality in people's care plans.

There was a complaints procedure in place but concerns raised by people to staff were not always escalated and addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor the quality of the service were not effective.

There was a registered manager in place. Staff spoke positively about the registered manager and the culture of the service.

The registered manager failed to notify the CQC of safeguarding investigations taking place.

Allied Healthcare Doncaster/Rotherham

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted in part by a notification related with the death of a person using the service. This incident is subject to the investigation of the local authority safeguarding team and as a result this inspection did not examine the circumstances of the incident. Our inspection was also prompted by several safeguarding concerns received in relation to missed care visits. The information shared with CQC indicated potential concerns around the management of risks therefore we decided to do a responsive inspection.

This inspection took place on 26 and 27 June and 3 July 2017 and was announced. We gave the service 24 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure management would be available to talk with us.

Inspection activity included visiting the office location to see the registered manager and office staff, and to review care records, policies and procedures and quality assurance documents. We carried out telephone interviews with people who used the service, their relatives and staff.

The inspection was completed by two adult social care inspectors on the first day, one inspector on the other two days 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. The expert by experience had experience as a family carer of a person living with dementia who used domiciliary care services. The expert by experience carried out telephone interviews with people who used the service, their relatives and staff.

Before the inspection, we reviewed all the information we held about the service including previous

inspection reports and notifications received by the CQC. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The registered provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We discussed this information during the inspection. We requested feedback on the service from the local safeguarding teams and commissioners.

We spoke with five people using the service and five relatives of people using the service. We spoke with ten staff; this included the regional director, registered manager, four care workers, two deputy managers, one care supervisor and two specialist nurses who were also part of the team. We looked at records for eight people using the service including support plans and risk assessments. We also looked at specific parts for care plans for another five people. We analysed three medicine administration records and twenty incident forms. We reviewed training records for seven staff and looked at recruitment and supervision records for four staff, including competencies and recent spot checks. We looked at minutes of team meetings, various policies and procedures and reviewed the quality assurance and monitoring systems of the service.

Inadequate

Is the service safe?

Our findings

People's comments included, "I feel very well looked after and very safe. The people in the office are always very nice too" and "I feel very safe with them. I wouldn't have a wrong word said about them. It's not an easy job they do but they are very conscientious". Relatives said, "My relative is very safe with the carers. I have absolutely no worries at all about safety" and "My relative is very safe with (named staff). They are really lovely. They are definitely more like friends." However during this inspection we found concerns about the safety of the service.

People were not always protected from abuse and neglect. One person told us they had not felt safe with staff because staff were "short tempered." They added, "They [staff] have to use a hoist to transfer me but they don't talk to me while they are doing it. They don't reassure me or make me feel comfortable." We asked the deputy manager to investigate this, they spoke with the person who did not want to take the concern any further; they also carried out a quality review and spot check on the staff concerned.

In the course of our inspection we found three people who had difficulty in making decisions about their safety were being locked at home by the carers at the end of their care visits. These people's risk assessments did not consider the risks involved with not being able to open the door in case of an emergency and what could be done to manage the risk. We shared our concerns with the management team; they could not tell us how many people were in the same circumstances. We contacted the local safeguarding team and made them aware of our findings. After the inspection, the registered manager showed us they had been in contact with social services and family members to discuss restrictions for those people affected and we saw evidence of risk assessments being updated. The registered manager also told us they were not aware of anyone else in the same circumstances, but would continue to raise awareness with staff about this issue.

Staff were trained in safeguarding people when they started working and later received annual refresher training. However, we could not be certain staff working with children had attended children safeguarding training and first aid for children. We shared our findings with the registered manager on the day, they could not find evidences of this specific training and they acknowledged this was an issue and would look into it. After the inspection, the registered manager sent us a training attendance sheet, but the content of the training was not specified or certificates of training provided.

These findings constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered provider was not always managing incidents of missed care visits safely. There was an electronic call monitoring service in place to alert staff in the office or out of hours if care staff had not attended the visit. However, this system only covered people living in the Doncaster area and had proven not to be effective as it was reliant on people having a landline. We were told a new system was going to be introduced in September 2018. The registered provider's safeguarding policy stated recurrent incidents of missed care visits were considered potential safeguarding concerns and the registered manager told us they

would raise all missed calls as safeguarding concerns. However, when we looked that the accidents and incidents log, we found instances where missed visits had not been escalated as safeguarding concerns. We asked the registered manager about this and they explained no harm had come to those people and that was why they had not reported it, however this contradicted what they had initially told us. This meant people supported by Allied Healthcare could not be reassured missed care visits would always be timely identified and acted upon in line with the registered provider's own policy.

This was a breach of Regulations 12 (2) (b) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We looked at how people's risks were assessed and managed and we found the registered provider did not have a consistent approach in place and was putting some people at risk of unsafe care. For instance, one person required support with moving and had a very detailed risk assessment explaining how their health conditions impacted on their ability to move and the method staff should follow. Another person who had a complex health condition and required repositioning during the night had a risk assessment that lacked detail. We spoke with the specialist nurse in charge of this person's care package and they acknowledged further details needed to be added to the risk assessment and they had plans to do it. We also found two people who had started receiving support more than two months ago due to being on end of life care did not have any risk assessments or care plans in place. We spoke with the registered manager about this; one of the care plans was updated by the end of our third inspection day and the other one was updated one week after our last inspection visit.

When we looked at team meeting minutes we saw "Carers voiced their concerns over care plans being out of date or non-existent". We asked one staff member about their views about the documentation about people's needs and care and they told us: "The main problem is people's care plans. They are mainly inadequate and, because I'm quite new, I really need some decent information so that I'm clear on what I need to do. I've never been introduced to any of the clients. It's a case of just going there and trying to make my way through the care plan and ask the client about thing as well." This meant people could not be reassured staff would always provide safe care adequate to their needs.

This constituted a breach of Regulation 12 (2) (a) (c) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We received mixed views about staffing levels. There was a system in place to manage staffing levels and the regional director showed us that according with current care packages and availability of staff there were no issues with staffing levels. One staff member told us they had no concerns because they had a "Fixed run that works well" but another staff member said, "There are some issues which are a lot to do with short staffing and too big a client list." People told us "The regular carers are all excellent but the company is definitely short staffed and there is a high turnover of staff as well." Another person said, "They are lovely people but I think they are overworked." One relative commented, "We've usually had a rota but we've not had one this week and I think it's because they are struggling to cover. We didn't get a carer last night and we've already been told that we won't get anybody on either Friday or Saturday night." We asked the registered manager about this and they explained the recruitment programme they had in place and the actions they were taking to address the particular issues of some care packages.

People could not be reassured staff would always safely support them with their 'as and when required' (PRN) medication and keep contemporaneous records. The service had a medicines policy and procedure and supported people with their medicines. Medicines records for each person contained personal information, the type, quantity and time the medicine should be administered. Records showed staff who

administered medicines had the appropriate training. However, we found people who needed PRN medicines were not supported consistently and records were not always accurate. One person had received two different PRN medications for six consecutive days, but it was not clear why. Another person required emergency medication to manage their epilepsy seizures. We found staff frequently supported this person with outings, but did not take this medication with them. We shared this concern with the registered manager and they told us they would review this care plan. Another person's medication record was missing three consecutive signatures. We asked the deputy manager about this, they checked the daily records and spoke with the carers and told us the medication had been given but not signed.

We looked at how medication was being audited and we found inconsistencies in the different geographical areas covered by the registered provider. When we looked at team meeting minutes these stated, "There are also a lot of missing entries (MARS – medication administration records) so we do not know whether the medication was given." We discussed this issue with registered manager and they told us they were planning to have a more consistent approach with auditing medication. This meant the systems in place to check the quality of the administration of medication were not always effective.

Incidents regarding people's care were monitored daily by the registered manager and these were reviewed monthly by the regional director. This enabled the manager to check action had been taken in response to individual incidents. However, the recording system used did not show how trends and learning were being used to continuously improve the service and prevent incidents happening again.

The above evidence constitutes a breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The service followed safe recruitment practices. The registered provider had a staff recruitment procedure in place. Staff employed were subject to various checks including references, proof of identification, eligibility to work in the UK and criminal record checks. The process assured the registered provider employees were of good character and had the qualifications, skills and experience to support people using the service.

Requires Improvement

Is the service effective?

Our findings

People shared mixed views with us about their staff's skills and competence to meet their needs. One person said, "I think they are all well trained and know what they are doing. There's been a different carer when one of the regulars has been ill or on holiday but normally it's the same faces every time which is important." Other person said, "It's fine when I have the regular carers but some of the people they send are not appropriate, they are too inexperienced. They sent one carer in the last few weeks who should have been given a full briefing before [staff] came but they hadn't told [staff] anything about my needs. As it happens, [staff] was very experienced from other agencies [staff] had worked for, so it was alright, but it would have been all the same to them if [staff] had no experience. I have to use [specialised moving and handling equipment] and it needs people who understand these things."

During this inspection we found one person's care plan indicated they required staff to be trained in behaviour support management and intervention. When we looked at these staff's training records we found one had their training overdue and the other did not have the training. We spoke with the registered manager about this; because of our enquiries this person's care plan was updated and it was established they no longer required staff to have specific behaviour management training. However we could not establish when this training had become unnecessary. The registered provider kept a record of all mandatory training and if any of it was overdue the rostering system could not allocate new work to staff, however this system was not always effective in making sure staff had all their required training in place, as evidenced above.

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 checked whether the service was working within the principles of the MCA. We found staff had completed mental capacity training and were aware of how this applied in practice. One staff member explained us they would "judge capacity day by day, ask if they [people] understand, ask why they don't want something done and if needed make a best interest decision for them." However, when we spoke with staff at the office and management, they told us they did not complete mental capacity assessments or best interest decisions as that was the responsibility of the commissioners of the care packages. When we looked at the care plans we saw some people had a 'Personalised Best interest/adult with incapacity plan', but this did not follow MCA guidance and it was inconsistently filled in. This meant the registered provider was not was not assessing people's mental capacity prior to decisions being made about their care and treatment and this constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. After the inspection the registered manager told us they had developed a template to assess people's mental capacity but were waiting for line management authorisation to start using it.

During our inspection we asked if people were being restricted of their liberty as part of their care. We found

three people who might lack capacity to make decisions about their safety were being locked at home by the carers at the end of their care visits. We reported this concern to the local safeguarding team. This meant people could not be reassured that any restrictions to their freedom as part of their care would be timely identified and the appropriate legal authorisations to be put in place. This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities). After our inspection the registered manager show us evidence of risk assessments being up dated in relation to this practice.

Records confirmed a programme of induction and on-going training was completed by staff in topics such as; dementia, moving and handling, safeguarding adults, food and hygiene, infection control, health and safety and medication. Staff told us the training provided was effective. For example, one staff member said, "'I have been with the service only a few weeks and I had a thorough induction. It covered lifting and handling, safeguarding, mental capacity act for example." The registered provider had a programme called care coaching made up of care staff who were excellent in their roles and were interested in coaching others. One staff member who had recently started working for the registered provider told us they did not feel fully confident after their induction, informed the management and "after two days of care coaching I got confident."

During this inspection we found staff were offered regular supervision and appraisals that looked at their practice, development and any concerns were discussed. We asked staff about the quality of their supervisions; one told us, "It's all right, just a formality but I feel supported, if I had any issues I would go to the manager." We also saw evidence of staff having regular assessments on their competencies to administer medication and provide care. This meant the registered provider was checking the quality of care provided by staff.

People were supported to eat a balanced diet that met their needs. The nutrition care plan for one person living with dementia indicated, "Eat sat in living room on my table, ensure this is in front of me so I can see my food, assist me with cutting large pieces of food into manageable pieces." Another person who required specialist equipment to maintain their nutrition had a particular feeding routine and staff were able to describe this. This meant people's specific needs were being assessed and staff had the knowledge to appropriately support them.

People were supported to access healthcare services in order to maintain their health. Care records showed regular contact with district nurses, GP's and social workers in order to discuss and arrange support that improved people's health. One relative told us, "My relative recently had a [urgent medical condition] and I couldn't drive myself because I'd had a recent [medical procedure] done. The carer went far beyond what [they] needed to do. [They were] supposed to finish at 3pm but [they] drove us to the hospital and stayed with us until 7pm. [Staff] is brilliant."

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed and staff demonstrated an understanding of how to meet these. One person's care plan stated, "Please make sure we are looking at each other when we are talking, always allow me time to answer so you can ensure that I understood what you are saying." One relative told us, "You need to know my relative because he is nonverbal and it's important to recognise his expressions to understand if he is happy or sad or if he has any pain. For example, he was very distressed the other day, I think it was the hot weather which upset him and when the carer arrived [staff] was able to soothe him."

Requires Improvement

Is the service caring?

Our findings

People had varied opinions about staff being caring and kind. People's comments included, "I can't fault the carers in terms of kindness. It doesn't matter how busy they are, they will always listen to me." Another person said, "The carers really go the extra mile all the time." However, one person said, "They [staff] don't like me and they're not patient with me." We shared this information with the deputy manager; they contacted the person to discuss and address their concerns and completed spot checks on the staff concerned.

One relative said, "One of our carers definitely needs some kind of award. [Staff] is just brilliant. I think [staff] is the very best in the agency." Another relative said, "My [Relative] idolises the carers and everyone involved gives me a bit of support as well."

Staff we spoke with demonstrated how they provided care that was respectful and promoted people's privacy and dignity. For example, one staff member said, "We keep people covered all the time with a towel, if family are visiting we ask them to leave if we are doing personal care." Another staff said, "We close the blinds and curtains during personal care." However, when we looked at team meetings minutes we saw one indicated, "People are talking about clients in clients homes. They all know about each other." We discussed this with the registered manager; they said they had not attended this team meeting but would look into what had been discussed and address this concern. During our inspection, we saw people's files with confidential and sensitive information were stored securely in the office.

People's choices in relation to the gender of staff supporting them were not always respected. When we looked at accidents and incidents we saw three different people had been supported with personal care by male carers when this was not their preference. This meant people's dignity was not always respected. We spoke with the deputy manager about this and they explained to us those incidents had happened because they had to cover care calls on short notice, only male carers were available and the priority was for people to have their care.

Some people's care records included a care plan summary which explained how they preferred to be supported. This included, what they wanted staff to do at the beginning, during and end of the care visit and how they liked staff to communicate with them. This provided guidance for staff on people's preferences. One person's care plan summary explained, "At the start of this visit I will be in bed usually asleep, if I am asleep please gently wake me up." However, during our inspection we found some people had their care plans written in a shorter template and these care plans did not include information about people's personal preferences when receiving care. This meant there was inconsistency in how people's preferences were being assessed by the registered provider.

Staff understood the importance of building relationships with people and most staff told us they had regular calls which enabled them to get to know people. People also told us that seeing familiar staff was important to them. One person told us, "I think the regular carers are marvellous. They try to plan their holidays so that at least one of them is here for me."

During our inspection, we checked if staff were supporting people to retain their independence and we confirmed this was being promoted by staff. One relative said, "My relative has been assessed as being at risk of falls but they are very careful to promote independence while keeping her safe. For example, if she wants to try and do something herself like sitting up in bed, they let her try but will be ready to steady her if needs be."

Requires Improvement

Is the service responsive?

Our findings

People and relatives shared mixed views in relation to the service meeting their or their relative's needs. One person said, "They are just amazing, brilliant. They will always wash my hair because I can't do it myself and they make sure I'm properly dried afterwards." Another person said, "I need help with everything. [The funding authority] are looking at moving me to a different registered provider because Allied don't tell carers what they need to do." One relative said, "They are not very good about changing my relative's pads. It's only a five minute job but they will come and say it doesn't need changing because it's dry." We spoke with the deputy manager about this concern and they said they would speak with the relative and staff.

The registered provider was not always assessing people's needs prior to commencement of the service. The service had a customer guide and the regional director told us this was given to every person using the service. The costumer guide stated, "Before your care starts, you will be visited by one of our team. They will discuss with you the type of service you need, what outcomes you wish to achieve, and how your staff can support you to achieve your goals." When we looked at people's care plans we saw two people were being supporting by the service without any care plans or risk assessments in place. These two people had started the service because they had end of life needs and their particular requirements had not been assessed by the registered provider. The lack of information and guidance could put people at the end of their life at risk of receiving inappropriate care and treatment. This constituted a breach of Regulation 9 (3) (a) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We found inconsistency in the quality of people's care plans and in how person centred these were. The registered provider was supporting people with complex clinical needs and these care plans were very comprehensive and included for instance information about people's medical conditions, breathing, manual handling and skin integrity needs. The registered provider was also supporting people with overnight care visits and these people's care plan were not very detailed in relation to their care needs, risks associated with those needs or their preferences.

People's care plans were regularly reviewed, but it wasn't always evident how people had been involved because the recording was not detailed. One person told us, "They came and talked to me about the care plan. They said that if I need more support they can come and review things with me. There's a meeting next week because they think I need more help. They do regular reviews anyway."

We found the system in place to manage complaints and concerns was not always effective. The registered provider had a complaints procedure in place and we saw evidence of this being appropriately followed. However, concerns raised by people to staff were not always escalated or addressed. One person said, "When I complain to them [staff] about being late all the time, they just say, 'We've got other people to see to, not just you.' I've never phoned up to complain, I just tell the carers." One relative said, "I've complained to the carers about them not changing my relative's pads when they should, but I've never complained to the office or the manager." We spoke with the registered manager about these concerns and they told us they would address them.

Requires Improvement

Is the service well-led?

Our findings

We asked people and relatives how they felt about the management of the service, comments included, "'I have no complaints. This is a good service" and "I can always get through to the manager and she's very approachable and listens to me."

However, during this inspection we found the service was not always well-led. We found quality assurance systems were not effective in recognising the issues we had identified at this inspection. The service carried out various quality audits of records including audits of medication administration records and 'customer' files. However, these were not being done consistently in the different geographical areas covered by the registered provider. The registered manager showed us evidence of audits being completed for people living in the Rotherham area. There were no records of actions being taken as a result of those audits and some of the issues found at this inspection related to people living in Rotherham. The registered manager told us they were planning to expand the auditing process in place to the other geographical areas covered by the registered provider.

The management of the service did not have access to people's contemporaneous records because people's records of care were not always collected in a timely way. The registered manager told us there was a care compliance system in place that would alert them if, for instance, daily care log books, medication administration records or quality satisfaction reviews had not been collected by staff. However, we found one person whose care and medication records had not been collected and this had not been previously identified.

The above evidence shows the registered provider's quality checks were not always being done in all geographical areas covered by the registered provider and on the most recent records of care delivered. This showed the systems used by the registered provider were ineffective and this constituted a breach of Regulations 17 (2) (a) (b) (c) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

During our inspection we found the registered manager had not always informed the CQC of safeguarding incidents that had taken place and were being investigated by the local safeguarding team. This is important to ensure CQC can monitor the safety of the service people receive. The registered manager confirmed they would submit all the required notifications going forward.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered provider used a survey to gain feedback from people. The results from last survey indicated 87% of the people thought the service was excellent, very good or good. However, it was not clear how this information was being used to improve the service.

The service had a registered manager in place. Most staff told us they felt the service was well led and the registered manager and office staff were approachable and supportive. One staff member said, "I can get in to the office and I will be seen." Other staff member said, "They [office staff] are good and will support if we

need." Another staff member commented, "I wish the management gave more feedback (about concerns raised about clients) and they would be easier to get hold off." We spoke with the registered manager about these last comments; they told us they acknowledged they had frequent meetings but were always available to speak with staff.

Staff spoke positively about the culture of the organisation. One staff member said, "We work very well as a team, branch manager is very approachable and escalates things, it's a nice place to work." The registered manager spoke positively about the care and office team and the quality of support staff delivered to people using the service. The service operated a 24-hour on call system which meant senior staff were available to provide guidance if required.

There were systems to ensure effective communication including text messages, phone calls and staff meetings to update staff. During this inspection, we saw evidences of regular staff meetings covering the different geographical areas and office staff. We read team meeting minutes and saw relevant discussions were being held in relation to the care delivered, staff training and good practice.

There was a business continuity plan in place to manage risks that might impact service delivery and put people at risk such as absence of the manager or extreme weather conditions. This meant risks to people were being minimised if there were issues with service delivery.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. On our arrival at the office we saw the ratings from last inspection were clearly displayed.

During the inspection the registered manager was open about areas for improvement. Throughout the inspection and after the inspection we requested records and information and most of it was provided within the agreed timescales. All staff we spoke with were helpful and co-operative.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to notify the CQC of safeguarding investigations taking place.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Some people did not have a care plan in place to guide staff to provide safe and person centred care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act (2005) were not supported through recorded mental capacity assessments to assess their ability to make decisions about their care and treatment.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's approach to risk management was inconsistent. Some risk assessments were very detailed, others were not and some people did not have any risk assessments. As and when required medicines and emergency medication were not always

managed safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found some people using the service were being restricted of their liberty without the appropriate legal authorisations or risk assessments in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality of the service were not effective.