Prime Support Service Limited

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Inspection report

Office 432, Houldsworth Mill & Art Centre
Houldsworth Mill, Houldsworth Street
Stockport
Cheshire
SK5 6DA

Tel: 01619756050
Website: www.primesupportservice.co.uk

Date of inspection visit:
25 January 2017
26 January 2017

Date of publication:
06 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 January 2017 and was announced.

Our last inspection of Prime Support Service took place on 27 September 2016 when we found multiple breaches of seven of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service inadequate and placed it into special measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. At this inspection we identified a breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was in relation to training. We also made two recommendations, which relate to staff recruitment procedures and systems to monitor and improve the quality and safety of the service.

Prime Support Service is registered to provide personal care to people living in their own homes. The service operates in the Stockport and Manchester areas. At the time of our inspection the service provided support to 15 people.

The service employed a registered manager. However, they were absent from the service at the time of our inspection, and the service was being managed by the two directors of the company, one of whom was the nominated individual. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following our last inspection the provider had produced a detailed action plan, and had made a range of improvements to the service. Whilst many actions had been completed, we saw others such as a review of staff training were still underway. The provider was working to the timescales identified in their action plan.

Improvements had been made to the way medicines were managed. A new format for medication administration records (MARs) had been introduced that identified the medicines the individual had been supported to take. There was evidence the provider had checked completed MARs returned to the office and had acted upon any identified errors. However, we found the provider had not sought advice from a pharmacist in relation to the requirement to crush a person's medicines. They confirmed they would do this as soon as possible.

Staff were aware of their responsibilities in relation to safeguarding. The provider had identified and reported safeguarding concerns to the local authority and the Care Quality Commission (CQC) as required. Records showed thorough investigations of any concerns raised had been carried out, with proportionate action taken to ensure people were kept safe.

People and relatives gave us positive feedback about the kind and caring nature of staff. People said they were now supported by the same staff on a consistent basis, which allowed staff and people using the service to get to know each other. There was evidence peoples' preferences in relation to the staff supporting them had been considered.

People told us staff were reliable and committed. No-one reported any missed calls, although we did receive feedback that there could sometimes be confusion over the rota that could lead to last minute staff changes. The provider used an electronic rota system, and was developing how they used this. Staff reported the rotas were working more 'smoothly' than they had previously.

Care plans had been completed that provided staff with detailed information about peoples' health and social care support needs, as well as any preferences they had in relation to how they received their care. People had had recent reviews with the provider where they had opportunity to provide feedback in relation to their care and preferences.

The provider had improved the training given to staff, and had provided training specific to individual's health care needs where this was required. However, there were continued gaps in the training provided to staff, and the provider acknowledged this was an area that was still under development.

Checks on staff member's identity and background had been completed to help ensure only staff of suitable character were employed by the service. However, the provider's decision around employment was not always clearly documented when these checks indicated potential concerns.

The provider was in the process of developing systems that would help them monitor and improve the quality and safety of the service. Was saw that simple checks and overviews were in place of areas including training, accidents, supervision and medicines.

Staff felt supported and had started to receive regular supervision, which they told us they found useful. The provider had not yet arranged any team meetings, but told us this was something they intended to do in the near future.

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.

Records showed that medicines had been administered as prescribed. However, advice had not been sought from a pharmacist in relation to crushing one person's medicines.

Staff were aware of their responsibilities in relation to safeguarding. The provider had reported and acted upon safeguarding concerns appropriately.

Checks had been completed when recruiting staff to help ensure they were of suitable character. However, the providers' decisions when making recruitment decisions were not always clearly recorded.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had started to receive regular supervision, and the provider had started to complete checks of staff competence.

The provider had put in place training for staff to help ensure they were able to meet peoples' identified support needs. However, there were gaps in training including first aid and the Mental Capacity Act.

There was evidence that the provider worked with other health professionals to meet peoples' needs. Staff gave examples of when they had contacted health professionals in response to a recognised change in a person's health.

Is the service caring?

Good

The service was caring.

We received positive feedback about the kind and caring approach of staff. People told us they were being supported by a consistent team of staff on a more regular basis.

People told us staff helped them retain as much independence

as possible in their daily lives.

People told us they felt they could trust the care staff and the provider to meet their care and support needs.

Is the service responsive?

Good

The service was responsive.

The provider had developed comprehensive care plans that detailed peoples' care needs and preferences.

People had received recent reviews of their care where they had been involved in reviewing their care plans. People had been encouraged to provide feedback on the service they received.

We saw evidence that complaints had been investigated and responded to promptly. People we spoke with told us they had been satisfied with the response to any complaint they had raised.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had developed a detailed action plan, and told us they were committed to improving the service.

The provider had started to develop systems to improve and monitor the quality and safety of the service. However, these were not fully embedded at the time of our inspection.

Staff told us they were happy in their job roles, and felt they received sufficient support.

Prime Support Service Limited

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 January 2017 and was announced. We contacted the provider the day before the inspection to make sure there would be someone at the office who would be able to facilitate the inspection. The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included any statutory notifications that the provider is required to submit to the Care Quality Commission (CQC) about safeguarding, serious injuries and other significant events that may occur in services. We reviewed the last inspection report and any feedback about the service we had received by phone, email or the 'share your experience' web-form on the CQC website. We contacted Stockport Healthwatch, commissioners of the service, Stockport safeguarding, social workers with previous involvement with the service and Stockport's quality assurance team for feedback. We received minutes from a meeting the local authority quality assurance team had had with the provider to review their progress against the actions plans in place. We considered this information as part of the inspection process and have referred to the feedback in the well-led section.

On this occasion we did not request a provider information return (PIR) from the provider. 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.

During the inspection we visited the provider's office and reviewed documents in relation to the care people were receiving. This included five care files, three medication administration records (MARs) and daily

records of care. We also reviewed documents related to the running of a domiciliary care service including records of safeguarding, training and supervision, audits and four staff personnel files.

We spoke with six staff, which included; the two directors of the service, the deputy manager and three care staff. We also received brief feedback via text message from two further care staff. We spoke with four people who used the service, and three relatives. We also received feedback via email from a fifth person who used the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2016 we found medicines were not being managed safely. This included issues with the way staff recorded the administration of medicines. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was meeting the requirements of the regulation.

The provider had introduced a new format of medication administration record (MAR). This new record listed the medicines the person was administered at that time. Staff had completed MARs, which demonstrated people had been administered their medicines as prescribed. One person's social services assessment indicated staff should crush the person's medicines before administering them. This was to help them swallow their medicines safely. We saw this direction was reflected in this person's MAR and care records. However, the provider had not sought advice from a pharmacist in relation to any potential risks from crushing this person's medicines. The provider confirmed they would seek advice and ensure further advice was sought if there was any change in the person's medicines.

At out last inspection in September 2016 we found the provider was not effectively assessing risk, and was not taking reasonable steps to reduce potential risk of harm to people. This included a lack of robust risk assessment and guidance for staff on how to meet individuals' needs. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had made improvements and was now meeting the requirements of the regulation.

We saw the provider had identified potential risks to peoples' health and wellbeing and had considered how to reduce the potential of harm occurring to individuals. We saw the provider had completed separate risk assessments in relation to any identified specific risks posed as a result of health conditions or limited mobility. This included local authority and provider moving and handling assessments. In most instances, there were care plans in place that provided staff with the information they would need to care for people safely and meet their needs. However, in one risk assessment and care plan we found instructions in relation to the use of a piece of equipment were incomplete. The provider confirmed staff were aware of the proper procedure, and told us they would update the risk assessment to ensure this additional detail was reflected.

There was evidence that people using the service and family members had been involved in developing risk assessments. One risk assessment we looked at identified a potential risk in relation to the person using knives, though we were unclear why this had been identified. We discussed this with the provider, and questioned whether this would result in a potentially restrictive and overly risk averse approach by staff. The provider told us this risk assessment was still being developed as staff got to know this person, and that this would be reviewed.

Since our last inspection the provider had ensured staff had received practical moving and handling training to help ensure they were competent in this area. Staff confirmed they had received this training, and one relative we spoke with told us staff now appeared much more confident in assisting their family member

when using their hoist.

At our last inspection we found safe processes were not always followed in the recruitment of staff. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of the regulation.

We reviewed recruitment records and saw processes were followed that would help ensure only staff suitable for the role were recruited. Staff had filled out an application form that provided a full employment history and had been interviewed prior to being offered a job. Other required checks had been completed prior to staff starting work, which including proof of identity, references from former employers and a disclosure and barring service (DBS) check. A DBS check shows whether the applicant has any known convictions, or is barred from working with vulnerable people. We saw one DBS showed the staff member had a previous conviction. We discussed this with the provider and were satisfied they had considered whether this affected the staff member's suitability for their job role. However, there was no recorded assessment in relation to the decision making process in relation to this recruitment decision.

We recommend the provider reviews their recruitment processes in accordance with best practice guidance.

At our last inspection in September 2016 we found the provider had not reported all safeguarding incidents to the CQC or local authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and the provider was meeting the requirements of the regulation.

Since our last inspection the provider had reported two safeguarding incidents, which had also been referred to the safeguarding authority. We spoke with one relative about a safeguarding concern that had been raised in relation to their family member. They told us they had been satisfied with the investigation into the concern and the response by the provider. The safeguarding team had requested the provider conduct investigations into the two incidents they had been notified of. We saw the investigations had been thorough and that the provider had taken appropriate actions to address any concerns. This included taking disciplinary action against staff and providing staff with additional support in relation to understanding professional boundaries. We saw a response from the safeguarding team had thanked the provider for carrying out a 'very thorough investigation completed in required timescales'.

Staff we spoke with understood their responsibilities in relation to safeguarding people from abuse or neglect. Staff were able to explain potential signs of abuse or neglect, and told us they would report any concerns to the provider. For example, staff said they would report unexplained changes in peoples' behaviour or any bruising or marks that appeared.

The provider told us there were sufficient numbers of staff available to cover all calls, and had no current staff vacancies. We reviewed the providers' electronic rota management system, which showed staff were assigned to all forthcoming calls. Since our last inspection the provider had voluntarily agreed not to take on any new care packages whilst the issues identified in our last inspection report were addressed. They told us this had meant they had reduced staffing levels, and said they would only take on new packages of care as staff were recruited to allow them the ability to do this safely.

The service did not use an electronic call monitoring system to check whether staff had attended calls and were where they should be. They told us this was something they were considering putting in place, and that

was required by the local authority if they started to commission a greater number of care hours. The provider said there had been one recent missed call due to a rota mix up, but that this had not had any impact on the individual. They told us the people they supported or a relative would call if staff did not turn up on time. People we spoke with told us they had not had any missed visits in the past year and that staff were reliable.

We saw staff had completed accident and incident reports when required, as well as reports of any 'near misses'. The records showed the provider had responded appropriately to help reduce any potential risk to people. For example, we saw the provider had contacted an equipment provider to repair a person's bed. Another person had sustained a fall that had not resulted in an injury. Their risk assessment had been reviewed and updated and their social worker informed. This would help ensure staff were aware of current risks and that there was adequate monitoring of this person's care and support needs.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2016 the provider was unable to demonstrate that staff had up to date training in areas needed to ensure people received safe and effective care. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in relation to training provision. However, we found evidence of an on-going breach of the regulation.

People we spoke with told us they felt the staff providing support to them were competent and understood what support they required. One relative said; "Yes, the staff are definitely competent;" and another person using the service told us; "They [the care staff] are first class. They are very dedicated and seem to have regular training. I can't fault them."

At our last inspection we raised concerns that staff did not have adequate training and information to enable them to safely provide support to a person with complex health conditions. The provider had put together a training package that was tailored to this individual's support needs. The provider had worked with a health professional in reviewing this person's care and they told us this professional had also reviewed, and was satisfied that the training package would provide staff with the knowledge and competence required to care for this person. We spoke with one staff member who worked with this individual who told us they had found the training useful. They told us they felt confident and able to meet all this person's health needs. The provider had assessed the competence of staff in relation to this person's care, and they talked about how one staff member had been taken off this person's care team as they had lacked confidence in providing some of the assistance that might be required. This showed the provider was taking steps to ensure only staff with the required skills and competences were supporting this person.

The provider had started to keep an electronic overview of the training staff had received. This showed staff had received recent training in areas including moving and handling (including practical training); safeguarding, medicines, person-centred care, dignity and nutrition. However, there were gaps in the provision of training in the key areas of first aid and the Mental Capacity Act. The provider told us they recognised training provision was an area that required further work, and they were in the process of reviewing their overall training and induction packages. Staff told us they received sufficient training to enable them to meet peoples' needs and to feel confident in their job roles. One staff member told us; "I definitely receive enough training. When I first started I wasn't happy with the amount [of training] I received. Now I feel things are a lot easier."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in September 2016 we found staff competence to carry out their role was not assessed and staff raised concerns that there was limited opportunity to discuss practice. Regular supervision was not being provided. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements

and was meeting the requirements of this regulation.

Staff said they had received recent supervision with the provider and told us they found these sessions beneficial. One staff member said; "Previously we weren't checked up on or asked if we were okay. My last supervision was good." The provider had planned for regular two monthly supervisions for staff, and all staff had received a recent supervision in December 2016 or January 2017. Records of supervision showed discussions were held that would help the provider monitor the competence of staff and provide them with support to develop in their role. For example, discussions were documented in relation to training needs and feedback was given by the supervisor. Staff were also able to raise any issues or concerns they might have.

The provider had recently started to undertake spot-checks of staff practice to help ensure staff were competent and to be able to provide them with feedback on how they could improve the way they supported people. We saw all staff supporting one person with complex healthcare needs had been observed for their competence in carrying out a range of care tasks, and actions were identified if further learning or development needs had been identified. We were shown examples of other recent spot-checks, although this system of checking staff competence was still in the process of becoming fully embedded, and was not at that time taking place on a planned basis. We saw new staff had had probation/performance review meetings when starting work. We spoke with one member of staff who had been more recently recruited who told us they felt their induction was adequate, but commented they would have liked more time to shadow other staff for certain people they supported. The provider told us they had recognised this shortfall, and were reviewing the induction process.

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

The provider told us most of the people the service provided support to had the capacity to consent to their care and support and that there were no practices in place that restricted peoples' liberty. We saw evidence that people's mental capacity had been assessed and that this was incorporated into their care plans. People had signed to consent to their care plans and provision of care and support.

Staff had not undertaken recent training in the MCA. However, they were able to demonstrate they understood the principles of this legislation. Staff told us they would always ask for peoples' consent before providing them with support, and this was confirmed by the people we spoke with. They also told us they would act in a person's best interests if they lacked mental capacity. The provider was aware that significant decisions made on behalf of a person who lacked capacity would require a formal best interests meeting, and they were able to discuss instances where they had been involved in such meetings.

We saw evidence in people's care records that the service worked with a range of health professionals to meet their needs. For example, the service had supported one person to a healthcare appointment and fed-back details of this review to the provider during our inspection visit. We heard the provider liaising with another healthcare professional and a person they provided support to, to set up a review for another person in relation to a possible health concern. We heard the provider give the person clear information and reassurance in relation to the reason for the required appointment. One person using the service that we

spoke with told us; "[Staff member] will always check and make a note. If there is any concern they will chase this with the district nurse." We spoke with a staff member who gave us an example of when the service had been proactive in identifying a change in a person's health that required treatment, and acting promptly on this concern by contacting an ambulance.

Good

Is the service caring?

Our findings

People told us the teams of staff that supported them had not always been consistent in the past, but said that this had now improved. Teams of staff, or in some cases individual staff members had been identified to work with different individuals'. We saw evidence that peoples' preferences in relation to their care staff had been considered when determining staff teams, and there was evidence this had been discussed with people during reviews of their care. The provider showed us how the rota software they used helped ensure only 'compatible' staff were put on the rota to work with individuals in line with their preferences.

Some people told us they received a copy of the rota for the staff coming to support them, and this was sent in advance, though this was not in place for everyone we spoke with. People told us that they usually knew the staff who came to support them and that they were informed if a new staff member was required to cover for their regular staff member. When possible, the provider introduced the new staff member. One relative told us; "They really take care of Mum and she likes them all. The level of care is brilliant. Dad is very comfortable and knows the carers coming in."

People using the service and their relatives were complimentary about the commitment and kind and caring nature of staff. One person said; "They [the care staff] are great. I've never been so well looked after. I've had various care agencies before and have never been as happy. They care and are friendly and supportive. It's all of them." A relative we spoke with said; "They are brilliant. They are the first care agency I've been able to trust and relax with. [Provider] is hands on and she employs good people. I know all the staff by name."

One member of staff we spoke with told us they had had experience with other care agencies in the past. They said in comparison to these other agencies, they felt Prime Support Service staff were 'really caring' and a 'switched on' team. People we spoke with told us staff respected their privacy and dignity. One person said; "They [the staff] definitely respect my privacy. They always knock and shout 'hello' before they come in." The care plans identified ways in which staff should help maintain people's privacy and dignity when providing care. Staff told us they would always ensure people were appropriately covered when providing personal care and would check that doors and curtains were closed. One person's care plan noted that staff should allow the person time and space to be on their own if this is what they wanted.

Staff told us they would support people to maintain independence by encouraging them to take part in their care, and to do what they could themselves. People we spoke with confirmed this was the case. One person told us; "Prime Support staff are by far the best agency we have had. They are friendly and reliable and go out of their way to support me in my daily life… Staff are always there to encourage me…" We saw evidence that the provider had considered whether advocacy services would benefit people who might require assistance in having their voice and point of view heard. We saw one case where the provider had made a referral to a lay advocacy service on a person's behalf to help ensure their point of view was represented by an independent person.

Peoples' care plans contained information about any communication support needs they had. We saw the provider had considered ways to support peoples' communication, including through the use of adaptive

technologies. During our visit we heard the provider contacting other professionals to try to make a referral for a person to a speech and language therapist (SALT) as it had been identified in a review of their care that this might be beneficial for them in developing their ability to effectively communicate with staff and others.

Good

Is the service responsive?

Our findings

At our last inspection in September 2016 we found care plans were not always regularly reviewed, had not been completed or did not contain sufficient information to enable staff or other professionals to understand the care and support needs of the individual. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was meeting the requirements of the regulation.

Comprehensive care plans were in place that identified peoples' care and support needs in relation to a range of support areas, including mobility, eating and drinking, activities, social and health needs. The provider had also produced detailed routines in relation to the support staff were required to provide people with on each visit, or in relation to specific tasks such as personal care. Care plans documented peoples' preferences in relation to their care, as well as interests and other information that would help staff get to know the person and understand their support needs. For example, the morning routine detailed in one person's care plan stated the person usually liked staff to make a cooked breakfast for them, but that staff should check on each occasion.

Whilst there was detailed information in place in peoples' care files we noted that in some instances the specific responsibilities of staff lacked clarity. This was because the information was either not consistent across all sections of the care plan and routines, or because old information that was no longer relevant had been kept in front of the most current information in the care file. Staff told us care plans had improved and gave them the information they needed to provide people with care that met their needs and preferences. One staff member told us; "The care plans are brill." However, this issue would increase the risk that any new staff introduced to people's care teams would not be clear about what care and support they were required to provide.

The care plans we looked at had been reviewed within the past three months, and the provider told us reviews would be completed every six months or sooner if there was any change in a person's needs or preferences. Records of the reviews showed that the person and where relevant, family members, had been involved and given opportunity to provide feedback on the way they received their care.

One relative we spoke with commented that if a new member of staff had to stand in for the regular care staff that they were not always aware of their family members' care needs before arriving at the home. A member of staff we spoke with confirmed that care plans were in place that they were able to refer to in such situations, but told us it was not always convenient to review the care plan when first entering someone's home. The relative suggested a task list for care staff would be beneficial, and the provider told us this is something they intended to develop.

The provider kept a record of complaints received. We saw two formal complaints had been raised since our last inspection. The provider had investigated these complaints, provided a prompt response, and taken appropriate actions to address the concerns, including issuing an apology and taking disciplinary action against a staff member. One person and two relatives we spoke with told us they had previously raised

complaints with the provider, and had been happy with the outcome of their reported concerns. One relative told us; "I was very happy my complaint was addressed and investigated."

The provider supported some people using the service to access activities as well as providing personal care. We saw peoples' interests and skills had been considered as part of reviews to help identify activities and opportunities they might enjoy. For example, one person's review identified they would like to go to a football match, and staff confirmed this goal had been achieved. Another person's review identified that staff would look into potential volunteering opportunities they could support the person to access. This would help meet people's social support needs, and identify opportunities for development and learning new skills.

People we spoke with told us staff were reliable and turned up on time. One relative told us the service worked flexibly, and said that in the past the provider had been happy to send a second staff member on the call if they were not going to be able to be at the home to assist staff. A member of staff we spoke with told us they felt the service went 'above and beyond' for people. They spoke about staff staying on with a person if they were unwell or needed a visit from the doctor, and working flexibly to support another person with their medicines at different times of the day in order to meet their needs and preferences. People we spoke with confirmed the service worked flexibly and responsively to meet their needs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2016 we found the registered manager did not have the skills and experience to manage the service effectively. We found this to be a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service continued to employ a registered manager, however they had been absent from the service for an extended period, and were not present during our inspection. We were therefore unable to assess whether the requirements in relation to this regulation were now being met. The two directors of the service had both taken up full-time management of the service and were being supported by a recently appointed deputy manager and member of administrative staff.

One of the directors told us they had been 'living and breathing' Prime Support, and that they were determined to turn the service around. A staff member we spoke with told us; "Prime Support is a fantastic company. We have worked hard behind the scenes and the whole team has come together. We were sad when we got the [inadequate] rating, but knew why and took the feedback on-board." The provider had produced a detailed action plan to address the areas of concern identified at our last inspection. Prior to our inspection, the local authority quality assurance team fed-back that the provider had been working hard to make the required improvements and that a lot had been completed. However, it was also noted that some of the identified timescales for completed had 'slipped' a bit. We saw the action plan had been regularly reviewed and updated, and demonstrated progress had been made in relation to a wide range of issues. Some actions on the plan were still to be completed at the time of our inspection, but these were within the identified time-frames on the action plan.

At our last inspection in September 2016 we found there were no systems in place to help the provider monitor and improve the quality and safety of the service. The provider had also failed to notify the CQC of all safeguarding incidents as they were required to do. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made, and the provider was meeting the requirements of this regulation.

The provider was in the process of developing and putting in place effective systems of audit at the time of our inspection. We saw overviews of staff supervision and training had been developed, and the provider was starting to use their electronic care management system to maintain better oversight in this area. The provider had also developed and carried out a recruitment audit, although this had not been effective at identifying the shortfall we found in relation to one staff member's recruitment record. We have discussed this issue further in the safe section of this report. The provider had also developed a simple overview of accidents and incidents that would help monitor the safety of the service. They acknowledged that this audit required further development to be fully effective.

We saw questionnaires had been sent out to people using the service to gain their views on what the service did well and any areas for improvement. These were not dated, so we couldn't be certain when they had been completed. The provider told us they would complete an analysis of the feedback when further

questionnaires were returned, although this had not been completed at the time of the inspection. People we spoke with confirmed they had opportunity to put across their views and opinions of the service via questionnaires and through the frequent contact they had by phone with the provider. Everyone we spoke with told us they were satisfied with the service they received. The provider had started to complete in-depth reviews of peoples' care during which they reviewed care documents including the care plans and risk assessments. The provider showed us a tracker that had been developed to help monitor this, although it was not completely up to date at the time of the inspection.

The provider told us records of care including daily notes and medication administration records (MARs) were returned to the office on a monthly basis. We found one instance where the daily notes had not been returned recently, which the provider said had been an error. This would make it more difficult for the provider to monitor that this person had received appropriate care and support. There was no complete audit of medicines, although the provider had introduced a check of the MARs when they were returned to the office. We saw this check had been effective at identifying medicines errors, and a note was completed to explain any actions taken or the reason for any discrepancy.

We recommend the provider continues to develop their systems for monitoring and improving the quality and safety of the service.

Staff we spoke with told us they felt happy and supported in their role, and felt the staff team worked well together. There was an on-call system run by the two directors and the deputy manager that staff could contact outside office hours if they had any issues or concerns. Staff told us they were always able to get hold of the on-call, or received a call back within a reasonable period. The provider had started to undertake regular supervisions and competency checks with staff. At the time of our inspection there had not been any team meetings, although the provider confirmed this was something they intended to put in place.

We received some comments from staff and people using the service that there could be occasional 'mix-ups' with the staff rota due to multiple revisions often being sent out. One relative also commented that they would prefer the rota to be completed further than a week in advance so they knew who would be providing their support on any dates of particular importance to them. Staff told us the rotas had improved and worked more consistently than they had previously. The provider also told us they were starting to use the care management software they had to manage the rotas more effectively.

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 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received sufficient training. Regulation 18(2)