Abicare Services Limited

Abicare Service Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 24, 25 and 30 May 2017. Abicare Service Ltd provides a domiciliary care service to enable people living in Basingstoke, Aldershot and the surrounding areas to maintain their independence at home. At the time of our inspection there were 66 people using the service, who had a range of health and social care needs. Some people were being supported to live with dementia and autism, whilst others were supported with specific health conditions including epilepsy, diabetes, learning disabilities and mental health diagnoses. At the time of the inspection the provider deployed 25 staff to provide 520 hours care per week to meet people's assessed needs.

At the time of the inspection the service had a registered manager, however they had recently tendered their resignation. The service had a registered manager. 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.

People were kept safe as staff understood their role and responsibility in relation to safeguarding procedures. Staff had undergone safeguarding training and understood the different types of abuse and how to recognise signs of such abuse.

Risks to people had been initially assessed and control measures put in place to minimise their occurrence. However, these were not reviewed regularly to ensure the most up to date guidance was provided to staff. This meant the provider could not be assured that all risks to people were being managed appropriately to keep people safe. One person had experienced a fall whilst being supported by staff which demonstrated staff did not always consistently apply safe moving and positioning practices. The registered manager had identified that some people's risk assessments had not been regularly reassessed and was in the process of ensuring this work was completed as a priority.

The registered manager completed a daily staffing needs analysis to ensure there were sufficient staff deployed to meet people's needs. However, this frequently required the registered manager, care coordinator and community team leaders to work overtime to provide hands on care, which deflected them from other responsibilities, such as reviewing care plans and risk assessments.

Records demonstrated the service had a recruitment process that met legal requirements and recruitment files confirmed that most required pre-employment checks had been completed. However, the provider had not consistently followed their own recruitment processes and taken appropriate action to assure themselves that staff employed were of suitable character to support people safely.

People's medicines were administered by suitably trained staff, although the provider had not consistently assured their knowledge and skill to do so had been maintained.

The provider's required training had not been updated in accordance with the provider's policy. This meant that the provider had not ensured staff were supported to maintain their skills at the required standard to meet people's assessed needs effectively.

People's care and support was always provided with their consent, although records did not always clearly reflect this. The registered manager and staff ensured best interest meetings and processes were followed to protect people's human rights.

Staff encouraged people to eat and drink sufficiently to maintain their health.

People and their relatives had a mixed experience in relation to the caring attitudes of the staff supporting them. Regular staff were caring and compassionate and treated people with respect although some staff were task focused and did not show an appreciation of the need to meet people's emotional wellbeing.

People were involved in making their decisions and planning their own care and support. If they were unable to do this, where appropriate, their care needs were discussed with their relatives or representatives. Regular staff treated people with dignity and respect. However this was not always demonstrated when people's regular staff were not available to deliver care.

People's care plans were not person centred and did not contain sufficient information relating to their personal histories, individual preferences, interests and aspirations. Regular staff knew such information. However when regular staff were not available other staff may not be aware of this information. This meant that the provider could not be assured that all people's needs were always being met.

People's care needs had not consistently been reassessed regularly which had resulted in their care plans being out of date. This placed people at risk of receiving inconsistent care and/or not receiving the care and support they need.

The provider had processes for seeking feedback in various ways such as quality assurance visits, telephone surveys and questionnaires. However these processes had not been completed effectively.

People had a copy of the provider's complaints procedure in a format which met their needs and knew how to make a complaint and raise any concerns about the service.

People and staff had experienced poor leadership and management until the appointment of the current registered manager in January 2017. However, the service was now demonstrating signs of improvement due to the commitment and dedication of the registered manager and their management team. The registered manager had created an open positive culture within service, which was supportive and inclusive.

The provider had quality assurance systems in place but these had been inconsistently applied since the service began, which meant they had failed to address the concerns identified in this inspection. The provider's leadership was reactive rather than proactive.

We found one breach of the Health and Social Care Act (2008) Regulated Activities 2014. 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 always safe.

People's risk assessments had not always been regularly reassessed which meant the provider could not be assured that all risks to people were being managed appropriately.

The registered manager completed a daily staffing needs analysis to ensure there were sufficient staff deployed to meet people's needs. However, this frequently required the management team to supplement care delivery, which deflected them from their primary roles.

The provider had not consistently followed their own recruitment processes and taken appropriate action to assure themselves that staff employed were of suitable character to support people safely.

People were kept safe as staff understood their role and responsibility in relation to safeguarding procedures.

People's medicines were administered by suitably trained staff, although the provider had not consistently assured their knowledge and skill to do so had been maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training had not been updated which meant the provider had not ensured staff were supported to maintain their skills at the required standard to meet people's assessed needs effectively.

The provider had not consistently applied their system of supervision to ensure staff were supported to deliver care based on best practice principles.

Staff recognised changes in people's needs in a timely way and promptly sought advice from health professionals.

People's care and support was always provided with their

consent, although records did not always clearly reflect this.

Staff encouraged people to eat and drink sufficiently to maintain their health.

Is the service caring?

Requires Improvement

The service was not always caring.

People experienced kind and compassionate care from their regular staff however this approach was not consistently provided if these staff were unavailable.

Some staff were task focused and did not sit and talk with people for any meaningful period of time, or focus on their wellbeing.

People praised their regular staff but were unhappy with the lack of respect demonstrated by replacement staff.

Replacement staff did not always understand how to maintain people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not experience person centred care planning.

People's care needs had not been regularly assessed which placed people at risk of receiving inconsistent care and/or not receiving the care and support they need.

The provider's processes for seeking feedback had not been applied consistently so learning from people's experiences had not been used to improve the service.

People had a copy of the provider's complaints procedure in a format which met their needs and knew how to make a complaint and raise any concerns about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had quality assurance systems in place but these had been inconsistently applied.

The provider's leadership of the service had consistently been reactive rather than proactive.

The registered manager had transformed the staff culture within the service to one which was open and inclusive, based on mutual respect and understanding respect which staff felt and appreciated.

People and staff, including whistle-blowers, were supported by the registered manager and issues they raised were dealt with in an open, transparent and objective way.

Abicare Service Ltd

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.

The inspection took place on 24, 25 and 30 May 2017 and was announced. The provider was given 48 hours' notice of the inspection to ensure that the people we needed to speak with were available. The inspection team consisted of one adult social care inspector.

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. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information contained within the provider's website.

During the inspection we spoke with the provider's registered manager, the nominated individual, the head of human resources and a compliance support manager. We also spoke with the care coordinator, a community team leader, two community team supervisors, the office administrator and twelve care staff. We spoke with 10 people and their relatives on the telephone to find out about their experience of the quality of care provided by the service.

We reviewed 13 people's care plans, including needs and risk assessments, daily records and medicines administration records (MARs). We looked at 12 staff recruitment files, and reviewed the provider's computer training records. We reviewed the provider's policies, procedures and records relating to the management of the service. We considered how comments from people, staff and others, as well as quality assurance audits, were used to drive improvements in the service. We also spoke with two care commissioners and three health and social care professionals who had engaged with the service.

Since the last inspection of this service the provider had changed their legal entity in August 2016. This is the

first inspection of this service under the new legal entity.

Requires Improvement

Is the service safe?

Our findings

People had mixed views about how safe they felt when being supported by staff. Some people told us they were supported by regular staff who knew them well, which inspired confidence and trust. Other people told us they did not have regular staff and were not confident in their ability to support them safely. One person told us, "The carers are very good and yes I feel safe and trust them." Another person told us, "Some of them are good but some don't know what they're doing." People did not consistently feel safe whilst being supported by staff.

Staff had access to the provider's safeguarding policy and local authority guidance about the actions they should take to keep people safe if they were at risk of harm or abuse. Staff were clear about their responsibility to report any concerns they might have about people's safety. Staff had undergone safeguarding training and understood the different types of abuse and how to recognise signs of such abuse. Staff told us the registered manager and office staff had been prompt to respond to their concerns, for example; when there had been medicine errors or concerns regarding potential financial abuse. People were kept safe as staff understood their role and responsibility in relation to safeguarding procedures. The registered manager ensured staff safety at work by effectively implementing the provider's lone worker policy.

Risks to people in relation to the provision of their personal care and environmental risks had been initially assessed and control measures put in place to minimise their occurrence. Designated staff completed needs and risk assessments, which promoted people's independence, while keeping them safe. People's risk assessments reflected the person's abilities and how staff should support the person's independence, for example; one person had a detailed risk assessment about how staff should support them to have a daily shower. Risk assessments gave staff guidance to follow in order to provide the required support to keep people safe. However, these were not regularly reviewed to ensure they contained the most up to date and accurate guidance required by staff to provide safe care. The registered manager had identified that some people's risk assessments had not been regularly reassessed and had scheduled these to be completed as a matter of urgency. We reviewed computer records and a white board which identified the scheduled reassessments to be completed by the registered manager and community team manager. At the time of inspection the provider could not be assured that all risks to people were always being managed appropriately.

Staff we spoke with understood people's needs and risk assessments and were able to demonstrate their knowledge of people's specific health needs, their medicines management, skin care and mobility care plans in practice. People were supported to move by staff who had received appropriate training and had their competency assessed by the provider's training coordinator. The registered manager told us where people were supported with moving equipment a risk assessment identified their needs and how they should be met. The provider had enabled staff to support people to move safely by providing the necessary information to do so. Staff had been trained in the use of people's individual support equipment before they were allowed to provide care for them. However, people told us that some care staff were not as careful as others which made them feel unsafe, for example; one relative told us about an incident where staff had not

supported their loved one in accordance with their care plan. This had resulted in their loved one falling from a commode onto the bathroom floor. This fall resulted in bruising and pain to their loved one's shoulder. This meant that staff had not followed the person's moving and positioning care plan on this occasion.

People told us there was a 24 hour on-call system to ensure they could speak with the management team at any time and knew this number was clearly displayed in their care plans. There were arrangements in place to keep people safe in an emergency. The service had a contingency plan in place to manage any emergencies which could affect the delivery of the service. Risks to people in the event there was an interruption to their service delivery due to an emergency had been assessed and rated, in order to identify who would be at the highest risk. This ensured the provider had prioritised people's care provision during such an event. People were protected as processes were in place to manage emergencies.

The registered manager told us they completed a daily staffing needs analysis to ensure there were sufficient staff available to meet people's needs. Rosters demonstrated that the required number of staff to meet people's needs was provided. However, this frequently required the registered manager, care coordinator and community team leaders to work overtime to provide hands on care, due to the unforeseen absence of staff. For example, the registered manager was scheduled not to work a bank holiday weekend but had to work exceptionally long hours on the three days to ensure people received their allocated visits.

People told us they had experienced a significant improvement in the consistency and continuity of care and support they received from staff since the appointment of the current registered manager. People told us that the timing of their visits had also improved since the appointment of the new registered manager and they did not experience missed calls. One person told us, "The organisation has improved and if the carers are going to be late you now get a call to let you know." Another person told us, "If there is a problem with your regular staff one of the managers comes out to make sure you don't miss your care." The management team made sure there were sufficient numbers of suitable staff to keep people safe and meet their needs. However the provider had not ensured sufficient numbers of care staff were employed and deployed in order to always meet people's needs.

The office administrator demonstrated the service's electronic monitoring system which identified when staff had arrived at a person's home and when they left. This enabled the management team to ensure people received their care and support at the required times to meet their needs safely.

Records demonstrated the service had a recruitment process that met legal requirements and recruitment files confirmed that most required pre-employment checks had been completed. These included the production of identity documents, references of good conduct in previous employment and full employment histories.

However, suitable references did not always confirm the details staff had provided and proof of their satisfactory conduct in previous health and social care employment, for example; one staff member had not explained why they had resigned from their previous role in 2014, where they had been supporting people with learning disabilities. The provider had failed to obtain a reference from this employer, although they had sent a request in 2014 and 2016 for this information. The provider had also not sought an explanation from the staff member in relation to this issue. Prior to selection prospective staff underwent a role specific interview to assess their suitability to support people in their own homes. However, these selection interviews were not always recorded to demonstrate the transparency of this process and the suitability of the candidate. The registered manager had already identified where the provider's recruitment process had

not been met and was taking action to address this. The provider had not consistently followed their own recruitment processes and taken appropriate action to assure themselves that staff employed were of suitable character to support people safely.

Staff told us they had completed safe management of medicines training and had their competency to administer medicines assessed annually by the registered manager, which records confirmed. Staff told us they felt confident managing medicines and that their training had prepared them to do this. Staff were able to explain the purpose of medicines prescribed for individual's health and wellbeing and supported people to understand what their medicines were for, so that people understood the importance of taking their medicines to maintain their health.

Sfaff had not consistently followed safe practice in relation to giving people their prescribed medicines and recording accurately what had been administered.

In the previous nine months there had been two medicine errors which had not been identified and reported by staff. One was identified by a health and social care professional and another was identified by a member of the person's family. The registered manager had taken prompt action to make sure people were safe and protected from the risks associated with medicine administration errors, such as ensuring staff had their competencies reassessed where required. We noted identified errors had not been repeated, which demonstrated the service had implemented necessary learning to keep people safe.

Requires Improvement

Is the service effective?

Our findings

People mostly praised their regular staff and told us they provided their care and support effectively, in the way they wanted. People and relatives mainly said staff had the necessary skills and knowledge to provide the support required and delivered care in accordance with people's care plans. However, some people had mixed experiences about the staff's ability to meet their needs, for example; one person told us that their regular staff were "Outstanding" but when other staff took their place it was a lottery, with some staff described as being "Incompetent."

Staff had completed an induction course and spent time working with experienced staff before they were allowed to support people unsupervised. This was confirmed by training records, the registered manager and staff. New staff told us, which records confirmed, that they could request further periods of shadowing if they were unsure about certain aspects of their training. The probationary period included regular supervisions and spot checks on their practice from supervisors and the registered manager. Staff underwent an induction programme before providing people's care, which ensured they had the appropriate knowledge and skills to support people effectively.

The care coordinator endeavoured to allocate staff focussing on their skills, experience and compatibility with the person they were supporting.

The provider's dedicated trainer had introduced the new Care Certificate into the provider's training schedule, which we saw within staff training files. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

Staff had undertaken the provider's required training for their role, which included moving and positioning, safeguarding, cleanliness and infection control, person centred care, medicines management, health and safety, fire safety, food safety, dementia awareness, pressure area awareness and first aid. Staff told us they were impressed with the quality of the provider's training.

Where staff were required to deliver more complex care to meet people's specific needs, such as catheter and continence management, they had completed individualised training to meet that particular need. Their competency to deliver such support was assessed by relevant healthcare professionals. This ensured that staff were supported to acquire the necessary skills to meet people's assessed needs effectively.

The provider's training schedule and staff training files demonstrated that the provider's required training in relation to safeguarding, medicines management, moving and handling, health and safety, dementia awareness and pressure ulcer awareness had not been updated in accordance with the provider's policy. This meant that the provider had not assured staff were supported to maintain skills at the required standard to meet people's assessed needs effectively. At the time of inspection we found no evidence to demonstrate this had had an adverse impact on people's care.

However, the registered manager had identified this training requirement and had arranged a programme of

training with the provider's training coordinator to ensure this was delivered as a priority.

The provider had a policy, procedure and established system of supervision to ensure staff were supported to deliver care based on best practice principles. The registered manager told us they had identified that the supervision system had not been operating effectively. As a result the registered manager together with community team managers had scheduled outstanding staff supervisions and unannounced spot checks, where staff care delivery was observed and assessed. This was to ensure staff provided care and support in accordance with people's care plans and recognised best practice. At the time of the inspection the provider could not be assured this was the case.

Staff told us that the registered manager encouraged staff to speak with them and was willing to listen to their views. Staff felt well supported by the registered manager and community supervisors. Staff consistently told us they had confidence in the registered manager and local management team and now felt effectively supported to carry out their roles and responsibilities.

The Mental Capacity Act (MCA) 2005 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 2005.

The registered manager and staff had completed training in the MCA, which the provider's training records confirmed. People had a communication care plan, which recorded how information should be communicated to them and how to involve them in decisions. Where people required support this identified people to consult about decisions made in their best interests. Where required, best interest decisions had been made in accordance with current legislation and guidance. Staff were able to explain to us the principles of the MCA and their role in supporting people to make decisions. The registered manager and staff ensured best interest meetings and processes were followed to protect people's human rights.

People told us staff always sought their consent before providing their care and gave continuous explanations about what they were doing. People and relatives told us the registered manager and senior staff had completed care plans and reviews with them and had ensured they consented to the care and support being provided.

People's care and support was always provided with their consent, although records did not always clearly reflect this. The registered manager was in the process of ensuring this was clarified where required. People were supported by staff who understood the need to seek people's consent and applied the guidance and legislation of the MCA 2005 in relation to people's daily care.

Some people had a lasting power of attorney (LPA). This is when a person has appointed another to make decisions on their behalf at a time when they lack the mental capacity to make them. People's care plans had fully recorded the details about whom staff were legally obliged to consult about individuals advanced decisions. An advance decision allows people to decide now about specific treatment they do or do not want to receive in the future. Its purpose is to ensure that if the person is not able to make decisions in the future they are not forced to receive treatment they would not want. Relatives involved in making decisions on behalf of family members had been legally authorised to do so. The registered manager was in the process of obtaining copies of all LPAs where required, to ensure this evidence was available in people's records.

People and relatives told us staff encouraged people to eat and drink sufficiently to maintain their health. One relative told us their loved one's regular staff "Made a fuss of them and always encouraged them to eat". People's specific dietary requirements, preferences and any food allergies were detailed within their care supports plans. Staff had completed training in relation to food hygiene and safety and knew people's food and drink preferences. People were supported to have sufficient to eat and drink to maintain a healthy balanced diet.

People were effectively supported by staff to ensure their health care needs were met. Staff promptly identified people's changing needs and where required arranged urgent referrals to relevant health professionals when, for example; to GPs, district nurses and occupational therapists. We reviewed care records which demonstrated when people had developed an infection, required support in managing pressure areas or with continence care they had been referred to relevant healthcare professionals. Staff provided care that was flexible to meet people's changing needs.

Requires Improvement

Is the service caring?

Our findings

People and their relatives had a mixed experience in relation to the caring attitudes of the staff supporting them. Most people told us that staff were kind and compassionate. One person told us, "One of the carers (named) is out of this world. It is all of the little things she does. She never rushes and makes you feel there is nothing more important at that time than you. We have had lots of carers from different agencies and she is the best we have ever had." Another person told us, "My carers treat me like one of their own and make feel special, nothing is too much trouble." The new manager is like a breath of fresh air because she listens to you and really wants to help you." Another person told us, "Most of the staff are very good but some are not very good, I'm not sure if they should be doing this job as they don't appear to care about you just getting their job done." People told us that most staff treated them with kindness while delivering their day to day care, which made them feel valued.

Staff had developed trusting relationships with people and were able to tell us about people's personal histories. Staff understood people's care plans and the events that had informed them. Most people told us staff knew them well, including their preferences about terms of address, bathing arrangements, times they liked to get up and go to bed were noted and followed. One relative told us, "The regular staff know (their loved one) really well but sometimes staff are sent who don't know them at all and sometimes it feels as if they don't really care."

Some people praised their regular staff but were unhappy with the lack of respect demonstrated by replacement staff. For example, one relative told us how gentle and careful their usual staff were whilst providing personal care for their family member, whilst other staff did not always understand the need to make sure they had their privacy and dignity maintained. One person told us they frequently had to provide further personal care for their loved one after Abicare staff had left. This made them feel some staff did not always respect or value their loved one. Staff did not always understand the need to make sure that people have their privacy and dignity maintained.

People told us their regular staff were caring and compassionate and treated them with respect. Staff had invested time and patience to build positive relationships with people, who enjoyed their company. People and relatives told us their regular staff took a keen interest in their lives and wellbeing and engaged in meaningful conversations with them that made them feel they mattered. People and relatives told us that some staff, who were not their regular staff, did not know them or their life histories, which meant they had no real empathy with them and made it difficult to build a rapport them.

People and relatives told us their regular staff had time to spend with them and always spoke with them in an inclusive manner, enquiring about their welfare and feelings. One person told us "My carers know me and my ways and always have time to stop and chat. They are never in a rush." This person told us, "If I had one thing I could change it is the staff who come at short notice in place of my usual carers. Sometimes they are in such a hurry to get things done it makes me feel like a burden." Some people felt that staff were task focused and did not sit and talk with them for any meaningful period of time, or focus on their emotional wellbeing.

One person was living with a condition which meant they experienced anxieties and different moods told us staff knew how to support them depending on how they were feeling. People were cared for by staff who were sensitive to people's presentation and mood and interacted with them accordingly.

People were involved in making their decisions and planning their own care and support. If they were unable to do this, where appropriate, their care needs were discussed with their relatives or representatives. However, where relatives and representatives were involved in decisions care plans did not always reflect the reason for this. This meant there was a risk that people's independence and right to choice may be restricted unlawfully.

People told us they were able to make choices about their day to day lives and staff respected those choices. People's care plans noted their preferred method of communication and detailed what information they should give the person to support them. People's care plans reflected how they wanted their care provided.

Staff told us they had equality and diversity training incorporated into their MCA and Human Rights training, together with dementia awareness training, which promoted the provider's values in relation to treating people with respect. People told us staff promoted their dignity by treating them as individuals. One person told us, "It has taken time but you can't earn trust overnight. I used to be embarrassed but now I don't even think about it because they make me feel at ease and you can tell they care about me."

Staff had easy access to the service policies and procedures which provided guidance to ensure people's information was protected and treated confidentially. Staff were aware of the importance of maintaining confidentiality and gave examples of how they did this. Staff told us the registered manager had reinforced the importance of confidentiality during staff meetings.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us their needs had been assessed prior to them receiving a service from Abicare. However, at the start of the inspection the registered manager told us they had identified people's care plans were not person centred. Person centred care planning puts people at the heart of the care they receive, providing them with the opportunity to take control and ownership of the process. It should consider people's desires, values, family situations, social circumstances and lifestyles; seeing the person as an individual, and working with them to develop appropriate plans to meet their needs.

The provider had identified that many of the service' care plans were very basic and did not contain sufficient information to ensure they were individualised to the person they referred to. For example; one care plan referred to a person who had suffered an acquired brain injury as requiring support with a learning disability. Other care plans did not contain sufficient information relating to people's personal histories, individual preferences, interests and aspirations. This meant people were at risk of receiving care which did not meet their needs.

The provider had engaged staff from within their care group to update the existing care plans to make them more person centred. The registered manager told us they were in the process of reviewing the updated care plans because they had been amended by staff who did not know the individual concerned or their personal living environments. People were not always at the centre of their care planning because care plans sometimes focused on the task, rather than them as individuals.

We reviewed care plans which identified people had specific health needs, for example; epilepsy, diabetes, dementia, autism, mental health diagnoses, visual, hearing and cognitive impairment. These care plans provided guidance to staff in relation to the personal care tasks to be completed but did not provide information about what action staff should take if people experienced symptoms in relation to their health needs. For example, there was no epilepsy protocol or guidance for staff to follow should a person diagnosed with epilepsy have a seizure whilst being supported by staff. This meant the provider had not ensured this person would receive treatment in a safe way if they experienced a seizure whilst being supported by staff. This person had not experienced a seizure for a long time and we found no evidence to demonstrate any adverse impact on the quality of their care.

Care plans relating to people living with diabetes did not provide guidance for staff to take appropriate action if the person experienced a hyper or hypoglycaemic episode whilst they were supporting them. This is when a person's blood glucose levels become either dangerously high or low and action needs to be taken to return these to safe levels. This meant the provider had not ensured that people would receive treatment in a safe way if they experienced fluctuating blood glucose levels whilst being supported by staff. Records demonstrated that people being supported with diabetes had not experienced fluctuating blood glucose levels and the quality of care they received had not been adversely affected.

Care plans supporting people with diabetes provided no guidance for staff in relation to their foot care, eye care or the requirement for regular check ups.

The care plan of a person diagnosed to be living with autism had no other information than the word itself. There was no information regarding the person's individual experience and how staff may be required to support them. Regular staff supporting this person knew their needs in detail and had the necessary training to provide the support required. However, the provider could not always be assured the person would be supported by regular staff. This meant the person may not always be supported by staff who knew their needs.

The provider had a policy and procedure to ensure people's needs were reassessed annually or more frequently when required, to assure that care plans reflected people's current needs and provided staff with up to date guidance to meet them responsively.

The registered manager had created a list of all care plans and risk assessments which were out of date on the office whiteboard. This demonstrated that 21 people's care plans and risk assessments had not reassessed in accordance with the provider's own policy. Four of these had not been reassessed since January, February, July and August 2015 respectively. Thirteen other care plans were in excess of six months overdue.

People's care needs had not consistently been reassessed regularly which had resulted in their care plans being out of date. This meant that their care plans did not or may not reflect their current needs. This placed people at risk of receiving inconsistent care and/or not receiving the care and support they need.

The registered manager confirmed they had completed a risk management exercise in relation to people who lived in the Basingstoke area because they had personally visited each person whilst delivering their personal care. This had provided reassurance that people's needs had not changed significantly placing them at serious risk of harm. The community team manager who covered the Aldershot area had completed a similar exercise to provide similar reassurance. However, 10 people living with a learning disability or autism in the Aldershot area had not received such a visit. We spoke with the member of staff who had been responsible for supporting these people. They told us they had requested extra hours to complete the out of date care plans, which the provider had declined.

Some of the people supported with a learning disability had chosen to use Abicare because of the quality of support provided by a particular member of staff. A care plan for one person living with autism showed they required two to one support whilst accessing the community. This meant when they were supported to access the community they required two members of staff to support them in order to keep them safe. There were no details explaining why the person required two to one support although this could be inferred from brief information which stated the person was a flight risk if confronted by a dog. There were no risk assessments in relation the person running off, being confronted by a dog, accessing the community or preventing social isolation. Other guidance within this care plan instructed staff to "Make sure I am safe", without any guidance about how to do this. We spoke with the staff member who told us that due to a significant improvement in the person's wellbeing they now only required one to one support whilst accessing the community. Whilst the staff supporting this person were aware of this significant improvement this was not reflected in the person's care plan. Regular staff knew how to support this person's needs however the provider had not always ensured people received care from regular staff. This meant there was a risk this person would not receive care which met their individual needs.

Most people's diverse needs in relation to their age, gender, and disability were understood and met by staff in a caring way. People's care plans identified people's religious, spiritual and cultural needs and wishes. However, we spoke with three people and their relatives who had requested staff of a specific gender, which had not always been arranged in accordance with their preference. Another person told us they preferred

more mature staff but frequently received care and support from younger staff. The provider had not consistently ensured that where people had specific preferences in relation to the age or gender of staff sent to support them, these preferences were accommodated.

The provider's failure to carry out person centred care planning with people, which was regularly reassessed to ensure their care plans were up to date and reflected their current needs, placing them at risk receiving inconsistent care or not receiving the care they need was a breach of Regulation 9 (Person centred care) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they had been involved in decisions about their care. One person told us, "The new manager came out to see me and took a real interest me and my life." Where people wanted support with important decisions records confirmed the people they wished to be involved had been consulted. People contributed to the assessment and planning of their care as much as they were able to. Relatives of people who were living with dementia told us they were reassured that the service had involved them in the assessment and care planning process.

People's records showed they had been supported to engage with their local community. A person told us they had been enabled to participate in activities they enjoyed, for example; going on shopping trips and visiting friends. There was guidance for staff about where the people preferred to be taken to pursue their interests. People were supported to follow their interests and take part in social activities of their choice, which enriched their lives and prevented them from becoming socially isolated.

The provider had processes for seeking feedback in various ways such as quality assurance visits, telephone surveys and questionnaires. These processes had not always been completed but the registered manager demonstrated how they had recommenced these processes. However, they were unable to provide examples at this time in relation to improvements made in response to feedback. The provider's processes for seeking feedback had not been applied consistently so learning from people's experiences had not been used to improve the service.

People had a copy of the provider's complaints procedure in a format which met their needs. Some people told us that they had become disillusioned with the ability of the service to meet their needs when they had raised concerns previously. However they had noticed a significant improvement in the attitude of the office staff under the new management. People consistently told us they felt that when they phoned to raise an issue now they were listened to. People and relatives knew how to make a complaint and raise any concerns about the service.

Records showed that since August 2016 six formal complaints had been recorded, investigated and where required action had been taken, in accordance with the provider's complaints policy. The registered manager had analysed the learning from incidents and where appropriate had addressed issues with relevant staff in supervisions. For example; staff supervisions in relation to a medicines error. People had benefited as learning and improvements were made as a result of complaints received.

Requires Improvement

Is the service well-led?

Our findings

People and staff told us they had experienced poor leadership and management until the appointment of the current registered manager in January 2017. However, the service was now demonstrating significant signs of improvement due to the commitment and dedication of the registered manager and their management team. The registered manager had created an open positive culture within service, which was supportive and inclusive.

People and staff who now raised concerns, including whistle-blowers, were supported by the registered manager and issues they raised were addressed. During the inspection the registered manager dealt with a whistleblowing issue in an open, transparent and objective way, which reassured staff members and the person using the service.

People and relatives told us they felt confident reporting any concerns or poor practice to the management team. Two health and social care professionals told us the registered manager was open and approachable and acted promptly to address issues they had raised. A healthcare professional told us the registered manager had worked effectively with their staff to implement guidance they had provided, which had a significant impact on a person's wellbeing.

Staff consistently praised the registered manager for effecting a complete transition in the culture of the service. Staff told us they had become disillusioned and did not feel valued. Staff consistently told us they were inspired and motivated by the registered manager to do their best and provide quality care for people. A common view held by staff was that the new registered manager had done an "Amazing job" to rebuild staff morale and pride in the service. We observed staff who were happy to visit the office and had a good relationship with the office staff. Staff consistently told us the registered manager readily praised them for their good work. One member of staff told us, "It is a refreshing change to get thanked by the manager for doing a good job rather than to be constantly criticised and put down."

Most people told us there had been a significant improvement in the way office staff communicated with them. People told us that their visits had been disorganised and they were not contacted if staff were running late. They said now they were called by the coordinator and office administrator to let them know what was happening.

The registered manager had been in post since the end of January 2017 and had completed their CQC registration process in April 2017. Since their appointment six notifications had been received from the service in relation to events which required the registered manager to inform the CQC, to ensure they had been recorded and investigated effectively. These notifications had been completed and submitted expeditiously detailing the incidents and appropriate action taken, for example; action taken in relation to a medicines error. The registered manager understood under what circumstances they were required to submit notifications.

At the start of the inspection the registered manager disclosed they had recently tendered their resignation

because they had not felt supported by the provider in their efforts to improve the service. The registered manager had frequently worked on their days off to ensure people were supported, which records confirmed.

Staff felt supported by the registered manager but not all staff clearly understood their roles and responsibilities which had not been clearly defined by the provider. For example, the acting community team manager and supervisor had not been provided with updated job descriptions. The registered manager told us they had not benefitted from an effective handover from the provider or their predecessor. The community team manager responsible for the service provided to people with a learning disability had received no recognised training in this area of care. The provider had not ensured that all staff had been enabled to carry out their role effectively.

The provider had quality assurance systems in place but these had been inconsistently applied since August 2016, for example; the systems had identified care plans and risk assessments required to be reassessed. Quality assurance systems had identified that staff training, supervision and appraisals had not been completed in accordance with the provider's own policy and needed updating. The registered manager was in the process of addressing the identified deficiencies and implementing the provider's systems effectively. However they were unable to demonstrate these systems had become embedded in working practices. This meant at the time of the inspection the leadership of the service was reactive. The registered manager told us they did not feel supported and were not confident they would receive the necessary resources to allow them to concentrate on their management role, for example; having time to effectively operate the provider's systems to ensure spot checks, supervisions, and appraisals were completed in accordance with the provider's policy. The registered manager told us they needed more time to focus on ensuring all of the out of date care plans and risk assessments were updated as a matter of urgency.

The provider did not operate an effective system to manage unforeseen staff absence, other than the registered manager and the management team providing hands on care.

The registered manager told us they were aware of concerns in relation to the continuity and consistency of calls when they were first appointed. They were able to demonstrate how they had listened and learned from this feedback and taken positive action in response, for example; Improvements in staff rotas and communication with people to inform them when staff were different to those scheduled or delayed.

The registered manager had high expectations in relation to the delivery of quality care practice which they clearly communicated to their staff. Staff told us the registered manager had clear values around treating people with respect and dignity which they reemphasised at every opportunity.

Records were mainly well organised, readily available and accessible to appropriate staff. People's records were stored safely and securely in accordance with legislation, protecting their confidential information from unauthorised persons. Processes were in place to protect staff and people's confidential information. However, at the time of inspection one person's care file was not available to be reviewed. This file has subsequently been located in circumstances which had not compromised the confidentiality of the document.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out an assessment of people's needs and preferences for their care and treatment. Regulation 9 (3) (a)(b)