A Plus Care Ltd

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

Summary of findings

Overall summary

A-Plus Care Ltd is a domiciliary care agency. At the time of our inspection they provided personal care to 23 people living in their own houses and flats. It provides a service to older adults and some younger disabled adults.

Not everyone using A-Plus Care Ltd receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

This was the first inspection for A-Plus Care Ltd in Bexhill since they became registered in November 2016.

The service had a registered manager. '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.' There was also a Care Co-ordinator, who supported the registered manager to monitor staff and manage office documents.

It was recognised that A-Plus Care Ltd is a fairly new provider and so were developing their systems for monitoring and auditing. However a number of shortfalls were found within record keeping which suggested current auditing processes needed to be developed. Staff had a thorough knowledge of people and their support needs, which meant where shortfalls were identified, there was limited impact to people. However support needs were not consistently identified within care documentation. There were limited assessments with regard to specific support needs, such as Diabetes, Epilepsy or positive behaviour support. Documentation that was missing, incomplete or due for review, was not always identified. Care documentation also lacked information on the process of decision making and did not always address the support needs of those people with fluctuating capacity. There was a potential risk that if unfamiliar carers were to complete call calls, they would not have all the information they required to support people.

Although people's views of the service were sought during reviews, no further feedback had been sought from relatives, professionals or other stakeholders. This was something that had been identified by the provider and registered manager and that they were in the process of implementing.

There were no protocols for supporting people who required medicines to be given on an 'as required' basis. Guidance needed further clarification to ensure that 'as required' medicines were effective for people. More detailed information was also needed for people who required medicines to be given covertly. This is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.

Staff told us that they received a wide variety of training and people and their relatives were equally confident that staff had the right skills and knowledge to support people effectively. However it was

identified that more specialised training relating to Diabetes, continence care, pressure care and positive behaviour support was needed for people who required support in these areas.

People felt safe and staff had a clear understanding on how to safeguard people and protect their health and well-being. There were suitable numbers of staff to meet people's support needs.

Staff spoke positively about their induction into the service and advised that regular supervision was given. These and regular spot checks meant that they felt positive practise was recognised and areas of improvement identified.

Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People and their relatives were positive in their views of care provided; they also achieved continuity of care through familiar staff attending care calls.

Records showed that the provider sought guidance from health professionals where additional support needs were identified. People, relative's and a health professional confirmed that they felt the service was responsive to needs that changed.

There was a clear complaints policy and people, relative's and staff knew how to raise concerns. Complaints were resolved within a timely manner and people were satisfied with outcomes.

People, their relatives and staff spoke highly of the management team and felt that an open, transparent and supportive culture was promoted.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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

Some aspects of the service were not safe.

More detailed assessments were required for people with specific support needs.

People and relative's felt that safe care was provided. Staff demonstrated good understanding of safeguarding processes and knew the procedure to follow for suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care plan documentation did not always identify understanding of the mental capacity act, particularly with regard to fluctuating capacity.

Further specialised training had not been identified for people who required support with specific health conditions or challenging behaviour.

Staff felt that the service provided a good induction and training programme which gave them the right skills and knowledge to support people.

People were supported to have good nutrition and were involved in choosing what they wanted to eat and drink.

Is the service caring?

Good

The service was caring.

People and their relatives were very positive about the caring nature of the staff team.

People and their relatives were confident that staff knew them and their support needs well.

Staff showed kindness and compassion when they talked about people and this was observed in interactions between them.

People had their privacy and dignity respected.

Is the service responsive?

Good

The service was responsive.

Each person had a care plan. Assessments were completed support needs identified before the care packed was started.

The provider sought support from healthcare and other professionals in response to any changes in people's needs.

Staff, people and their relatives were knowledgeable about the complaints process and felt comfortable raising any issues.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality audits were not consistently completed and therefore incomplete or missing records were not identified.

Staff and the registered manager knew people well however care plans lacked consistency and did not always identify all care needs.

People, staff and relatives spoke positively about the management team and felt well supported.

A Plus Care 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.

This inspection was announced. We gave the service 48 hours' notice of the inspection visit because the manager is sometimes out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 11 January 2018 and ended on 17 January 2018. We visited the office location on 11 January 2018 to see the manager and office staff and to review care records and policies and procedures. Following the office inspection, we visited some people in their homes to gain their experiences of care provided and to review their care documentation. We were also able to view interactions between people and staff.

Two inspectors were present at the office on the day. Although not present at the location, an expert-by experience supported the inspection team by speaking with people and their relatives by telephone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked the information held regarding the service and provider. This included previous inspection reports and any statutory notifications sent to us by the registered manager. A notification is information about important events which the service is required to send to us by law. We also reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make.

On the day of inspection, we spoke with four people who used the service about their day to day experiences. We spoke with four relatives, six staff, the Care Co-ordinator and the registered manager. We spent time reviewing records, which included four care plans, six staff files, four medication administration records, staff rotas and training records. Other documentation that related to the management of the

service such as policies and procedures, complaints, compliments, accidents and incidents were viewed. We also 'pathway tracked' the care for people living at the service. This is where we check that the care detailed in individual plans matched the experience of the person receiving care.

Following the inspection we visited three people in their homes and viewed their care plan documentation. We also spoke with a health professional involved with support for a person and the local authority.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe when supported by staff in their home. We were told, "I feel completely at ease when they come in" and "I never feel unsafe". One person, who was supported by staff to receive their medicines, said, "they get my blister pack and make sure I take my pills – I manage the rest – it all goes very smoothly."

Relative's confirmed that they felt their family members were kept safe. We were told, "Yes, I most certainly think that my relative is safe" and "I have no concerns about the safety of my relative when they are being supported by the carers." Another relative emphasised how grateful they were when staff raised concerns that they were unaware of. This was dealt with immediately and the relative felt that the provider had their relative's best interest at heart.

Despite this positive feedback we found some practice that was not safe.

Assessments of risks, both personal and environmental were undertaken for people in their homes. This included risks surrounding mobility, falls, pressure care, moving and handling, trip hazards in the home and also risks outside the home, such as dimly lit streets or restricted views when leaving the driveway. Fire risks such as oxygen machines and people's placement of clothes to dry had also been considered as part of the environmental risk assessment.

However, there was a lack of risk assessment to meet some areas of individual need and to promote people's safety and well-being, for example, in relation to the management of epilepsy. There was limited information about what a typical seizure looked like for the person, if there were any known triggers and the actions staff needed to take if they witnessed a seizure, There was no guidance for staff on diabetes and how to recognise signs of high or low blood sugars and the actions staff should take. Staff did not directly support people with managing their Diabetes. Either the person themselves or a district nurse was responsible for monitoring blood sugar levels. We spoke with staff about these areas and staff were able to tell us the actions they would take to meet people's needs. However, if regular staff were not able to visit, there would be a risk that unfamiliar staff would not have the understanding of people's support needs or recognise signs that they were unwell and this could leave the person at risk of not receiving safe and appropriate care promptly.

People who were supported with medicines told us that they received them on time. We viewed Medicines Administration Records (MAR) for some people and found that people were given medicines as they were prescribed and recording this accurately. Relatives confirmed that they felt staff had a good understanding of their relative's medicine support needs. Some people took medicines on an 'as and when required' basis (PRN). Whilst there were no written guidelines, staff demonstrated that they knew people and their support needs surrounding medicines and therefore there was little impact on people. However this was an area that required improvement and has been addressed further in the Well-led section of this report.

One person required medicines to be given covertly. Staff were able to tell us how to support the person, for

example what food medicine was given in. They were able to demonstrate how they ensured the person received all their medicine and actions they would take if this did not happen. There was a letter from the person's GP confirming that medicines should be covert and the registered manager advised that a person's relative had been involved in the process.

Staff had completed training in the safe administration of medicines and records showed that this was up to date. Medicines administration was observed where required during spot checks. The registered manager was aware of regularly ensuring that staff were competent in medicines management and had already planned to introduce medicine competencies a year after staff had completed training.

Some people displayed behaviours that challenged. Examples of this were refusing support or shouting; an incident report identified how one person had called paramedics repeatedly and emergency services had contacted the agency as they were not considered emergency situations. The registered manager and staff knew how to support the person and had taken appropriate action to seek further professional advice. They contacted a number of professionals to get to the root cause of the falls and reassured the person. This holistic approach meant a reduced number of calls made to paramedics. Another example was identified when one relative explained how their relative could 'be stubborn and refuse to move'. They explained that staff who visited regularly knew how to encourage and support the person at these times.

There were sufficient numbers of staff to support the needs of people in their homes. When staff were unwell, care calls were covered by the registered manager or care co-ordinator. People and their relatives told us that they always had the same staff visit them. If they had a day off or holiday, another familiar staff member would visit. This ensured that staff knew the people they were supporting well and provided continuity of care.

There were sufficient contingency plans for emergency situations. An example of this could be in severe weather conditions where carers are unable to travel. The registered manager told us how they would manage an emergency situation and had completed a 'Priority care calls' sheet. This identified people who could be at higher risk due to living on their own or in isolated areas and were incorporated into their contingency plan.

Staff were recruited safely. The provider had completed thorough background checks as part of the recruitment process. This included applications to the Disclosure and Barring Service, which checked for any criminal convictions, cautions or warnings. References from previous employers were also sought with regard to their work conduct and character and these were evidenced in staff files.

People were supported by staff who knew how to keep them safe. Staff were able to demonstrate their knowledge of current practise and understanding of processes to follow if they suspected abuse was happening. Accidents and incidents were clearly recorded with evidence to show that measures were put in place to prevent incidents from reoccurring. An example of this was a person who had recently experienced a number of falls. The provider sought advice from the GP and made a recent referral to the Falls team immediately.

We saw good practices with regard to infection control. People and relative's told us that staff had access to and wore personal protective equipment (PPE). Soap, gloves and aprons were readily available and used frequently. Staff were up to date with Infection control training and demonstrated a good understanding of how to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

People felt that they were supported by staff who were suitably skilled and trained. We were told, "My carer certainly knows what she is doing" and, "I never have any doubt to how skilled staff are – they are very confident and know what they are doing." Relatives agreed, telling us, "I know they attend training regularly and it shows" and, "I have never had to question staff about what they are doing – there are no problems at all."

People told us that they were always given choice and asked consent before care. One person told us, "Staff are always very polite and ask my consent to do anything" and another said, "They give me options of what is available and then I choose what I want." Staff demonstrated their understanding of involving people in decisions and asking their consent before providing care and support. They had knowledge of the Mental Capacity Act and how it related to the people they supported.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

Although staff showed understanding of choice and consent, people's documentation held minimal information about mental capacity. There was a lack of information about people who had fluctuating capacity. In several support plans there was no record of the choices people could make and areas where they may require support to make a decision. In one person's support plan, the 'Service user consent' form had been signed by a relative, but no assessment had been carried out to determine the individual person's capacity and whether the relative had the legal authorisation to give consent on a person's behalf. For some people, it also needed to be clarified whether they had an advocate, or power of attorney. We recommend the provider uses a reputable source to update their assessment and recording of mental capacity and update their practice accordingly.

Evidence showed that staff attended regular training that included moving and handling, health and safety, first aid, equality and diversity, mental capacity, Dementia awareness and food hygiene. Staff demonstrated an understanding of people who they supported however confirmed that they had not attended more specialised training that related to the specific needs of people such as diabetes, continence needs, pressure care or positive behaviour support. We recommend that the service explores training for staff, based on current best practice that will increase their knowledge of areas specific to the needs of service users.

Staff spoke very positively about their induction. They advised that as part of the process they met people who they would be supporting and also shadowed more experienced staff so that they could fully understand support needs. New staff completed the Care Certificate as part of their induction. The Care

Certificate is a nationally agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is comprised of 15 minimum standards that should be covered for staff who are new to care. There were also opportunities for staff to complete a Qualification and Credit Framework (QCF) in Social Care for those who wished to develop their skills and knowledge. A QCF is a work based award that is achieved through assessment and training. To achieve a QCF, candidates had to prove that they had the ability (competence) to carry out their job to the required standard.

Staff advised they received regular supervision and found this helpful and informative. The registered manager was aware of the need for appraisals; however these were not implemented at the time as staff had not worked at the service for a full year. Staff felt that supervisions addressed any goals or aspirations they had as well as areas for development.

People's nutritional needs were met. People who required support reported that they were given choice and control over what they wanted to eat and drink. Food and drinks were made available so that they could be easily accessed by people when carers left. An example of this was a staff member who asked a person whether they needed any more snacks by their bed and ensured fresh water was on the bedside table. Some people advised that staff went shopping for them and that they were always asked what they wanted. During one home visit, we observed staff checking dates on food in the fridge, advising the person if it was out of date and then asking permission for whether they could dispose of it. For people who required monitoring to ensure they drank enough, fluid charts were used; an example of this was for one person who developed an infection. Staff noted when they had offered drinks and how much the person had drank, to ensure that enough fluids were being taken.

The service supported people to maintain good health with input from health professionals on a regular basis. Records showed that people were supported to access their GP, chiropodists, dentist's and health appointments if they became unwell. This was mainly arranged for people in their own homes. One person told us, "If I don't feel right, I tell the carers and they phone my GP if I need them to." The registered manager gave another example of a person who developed sore skin and feet; the provider organised regular visits from the person's GP and chiropodist. One relative told us how carers had come in early to support their relative so that they could access an early hospital appointment.

People advised that they had never had a care call missed and that if staff were late, they were phoned with an explanation. The registered manager showed us a computer system that supported staff delivery of care. Staff confirmed their arrival and departure from people's homes with the use of a programme on their mobile phones. This meant that the registered manager could ensure that people received their care calls at the right time. It also ensured that staff safety could be monitored in line with their lone working policy.

The registered manager explained how they had recently relocated their office to the centre of Bexhill. This was because their previous base was isolated and meant that staff and people could not access it easily. The registered manager advised that since moving, it had been much easier to access, particularly for those who did not drive as links to public transport were very good. This meant they were receiving more visits from people and that staff meetings were much more frequent.

Good

Is the service caring?

Our findings

People spoke highly about the caring nature of staff who supported them. We were told, "We've had over and above service", "they provide excellent care", "they're absolutely brilliant" and "Is my carer nice? Of course she is!" Relatives advised that they were impressed with the quality of care provided by staff to their families. One relative said, "in my opinion they provide 1st class care – they are very helpful people and are always smiling." Another relative said, "It is obvious that my relative likes and gets on with their carers. They know them well and are very caring."

Staff felt they were given enough time to support people so that they not only met their support needs but had time to get to know who they were as a person. One staff member, who supported a person with dementia, told us, "most of the time we sit and talk about the person's life, their interests and family. This is particularly important to them as they forget things." People confirmed that they did not feel rushed and that staff took time to see how they were. We were told, "they make time to see how I am and seem to really care" and, "My visits and the length of time they spend here are just right".

We viewed numerous thank you cards from people and their relatives that emphasised their satisfaction with care provided. Comments included: 'Thank you for the excellent care and support', 'Assistance of the highest standard', 'extremely satisfied with care' and 'staff all very friendly'.

Staff told us that they enjoyed working for the agency and caring for people was "what made their day." One staff member said, "I love supporting (person). We know each other well and it feels like visiting a friend, rather than work." Another told us how, "(person) really brightens my day and makes me laugh". The registered manager told us that they were happy that they had such a good team of caring staff. They gave an example of a person who was declining care and only allowed one staff member to support them. The staff member initially visited the person on their day off while other staff were gradually introduced. The person now has accepted other carers.

It was clear that staff had an understanding of people's likes, dislikes and preferences. People advised that they received the same carers each time and that this made them feel that they knew them well. Relatives confirmed this, one saying, "Continuity of carers is very important for us and our relative gets this". The registered manager advised that they take time to match staff to people, by looking at interests they may have in common and staff's skill and personality. This meant that people received the right care by staff who they got on with.

During home visits, we saw interactions between staff and people. Staff were observed to be kind and attentive to people's needs. One person said about their carer, "this one knows exactly how I like everything and where it's all supposed to be. I don't have to worry about a thing". Another person with dementia appeared to have a good relationship with a carer; there was lots of joking and laughter and the two hugged when the carer arrived. Staff also showed a caring attitude when the person forgot where they were. The staff member reminded them that this was their home, showed them personal items and reminded them how long they had been there and who their family were. This demonstrated their knowledge of the person

and how to support them if they became anxious or confused.

Staff demonstrated a good understanding of respecting privacy and dignity and people confirmed that they were treated this way. One person said, "my carers treat me with utmost respect." Another person gave examples of how staff were sensitive when supporting them with personal care. Staff also had good understanding of maintaining confidentiality.

People felt that their independence was respected and promoted by staff. One told us, "they ask me what I need help with rather than assuming. I like that." A relative confirmed this, saying, "they always talk to my relative and encourage them to do things for themselves. Although my relative can't do much on their own now, it's good that staff still encourage them".

The caring principles of the service included the well-being of their staff. We were told by staff that they felt cared for by management. Comments included; "I'm happy working here, they understand and support me to do well", "Everyone gets on, they are very nice people to work for" and "Feels like family, a real team". Another staff member advised that every weekend staff receive an email from the registered manager thanking them for their support and it helped them to feel valued. "It's lovely to get a message from the manager at the end of a busy week to say thank you for our hard work".

Good

Is the service responsive?

Our findings

People felt that the staff and provider were responsive to any changes to their support and also to any concerns that they had. One person said, "When the regular carers are on duty it is noticeable how sensitive they are to any problems". Another told us, "There is always a willingness to sort things out or improve things." Relatives were in agreement, one confirming, "Oh yes, there is definitely a will there to sort things through". Another relative expressed how grateful she was to staff following a recent incident with their relative; "The carers were wonderful and even stayed and slept over. A Plus did not charge for this either."

People and their relatives felt that they received care that was specific to their individual needs. We were told, "They cover all my needs", "they know what help I need and do everything I need them to" and, "My relative can be a demanding person with their needs and expectations but they (A Plus) have taken on board their needs and done a lot for them". Pre-assessments were completed with each person before a package of care began and identified their support needs, preferences and wishes. This included awareness of specific sensory or communication needs. An example of this was for a person who was hard of hearing. The registered manager advised their social worker of this when they were due a review; specialised equipment was provided so that the person could hear what people were saying and be fully involved with their review. Another example was given by the registered manager of a person with sight impairment. Staff would knock and call out their names so as not to startle the person when they visited.

Staff confirmed that they were given good information about new clients and their individual needs and on some occasions staff had been able to meet with them before the service started to alleviate anxiety that the client may have and to help build up a good rapport. Information gathered from the assessment had been used to formulate the person's care plan. There were timetables that detailed times of care calls, support required at each visit and where items could be found in the home. Most care plans included an 'About me' section that included information about the person's life, their family and others closest to them, interests and preferences. These were completed with people during their reviews.

The provider responded to people's changing needs by taking appropriate actions to support them. An example of this was a person who had a sling and shower chair provided that did not have head and neck support. Staff felt that it was unsafe and sought advice from the social worker and occupational therapist. The person was given a specialised shower chair and new sling that provided the right support for their needs. Another person was showing signs of developing dementia and other mental health related issues. This information was fed back to the person's social worker and they were placed under the Mental Health Team, who were able to provide additional support they needed.

The registered manager gave another example of a person requiring moving and handling assistance on stairs. They had concerns that one staff member was not enough to support. An occupational therapist was sought for an assessment at the person's home and they now received support from two staff. This has decreased the risk of harm to the person and staff.

We spoke with a health professional that was involved with the service due to the support needs of a person.

They told us they felt that the provider was responsive of the person's needs. "They contacted me as they were concerned about a person's welfare. They also made a referral to the Falls Team. They were in contact with me following my assessment to gain feedback. They seemed very concerned about the safety of the person and also the staff supporting them."

Although activities were not always part of the support provided to people, there was evidence to show that staff promoted activities on their visits. One person and staff told us how they went into town or for a walk sometimes and about a café they had gone to before Christmas for hot chocolate. The same staff member advised how they had arranged for a gardener to come to the person's house; this was so the garden could be cleared and the person could sit outside. The provider held a MacMillan coffee morning at their office in line with their opening day – the registered manager advised that people and their relatives really seemed to enjoy this and that they would like to introduce more social activities like this. The provider also talked about plans to hire a minibus so that people could be collected from their homes.

People were actively encouraged to express their views about the service and were given clear information about how to make a complaint. People told us, "If I have any issues, I ring the registered manager." and, "I haven't had to complain but I know how to." The provider had a complaints policy. The registered manager had developed a version of the document that had larger font and was simplified. Phone number's with who to contact with any issues were highlighted. This was so it was easier for some people to understand the complaints procedure. We saw copies of this in people's documentation at home.

People who had raised issues felt that they were listened to and a response was made straight away. An example of this was a person who complained about a staff member being late and producing 'unsatisfactory work'. Records showed that the registered manager spoke with the person immediately about their concerns and then with the staff member to discuss expected levels of work. During this meeting it was identified that the staff member was having difficulty with completing daily records effectively; the registered manager booked them on 'Record Keeping' training to support with this. There was also evidence to show that the registered manager discussed actions taken with the person and that they were happy with the outcome.

People told us that they participated in reviews with the Care Co-ordinator regularly. During this time they discussed current support needs and reviewed documentation in the home file. They also completed a satisfaction survey which gave them the opportunity to discuss any concerns they may have.

At the time of inspection, no person required support with end of life care. The registered manager advised that they had tried to have some discussion with people during initial assessment and reviews about any wishes they may have, however most declined to discuss this. We saw evidence that people who had chosen not to be resuscitated had a Do Not Attempt Resuscitation (DNAR) form displayed in the front of their support plans. These had been reviewed regularly with the person and their GP.

Requires Improvement

Is the service well-led?

Our findings

People spoke very highly of the registered manager and of how they felt supported and listened to. We were told, "the registered manager is wonderful, I've been with other care agencies and there's no-one like them" and "they work so hard and are so kind." We were also told how quickly the registered manager responded to any concerns. One person said, "I had a concern that was dealt with straight away with minimal fuss – I was very pleased."

Relatives agreed that they felt the registered manager was supportive of them and their families. One relative said, "I don't know how they manage everything the way they do – I am constantly impressed." Another relative described them as, "Always jolly and helpful – I can speak to them if I have any concerns".

Staff felt that they were well supported by the registered manager and part of an open and empowering culture. We were told, "There is good team work, we all work well together", "Good leaders, everyone works well" and management were "flexible and supportive". All staff felt that communication between the registered manager and the team was good and that they could discuss any concerns they had freely as they felt listened to.

The registered manager also felt supported by the nominated individual of the service and told us, "They are very reasonable. They listen to suggestions and want to make things better. I feel very well supported and they always make time to listen."

Despite this positive feedback, there were some areas that we found were not well-led.

As a new service, the registered manager and nominated individual had introduced systems to monitor the service provided. However, in some areas these were still being developed and needed further exploration to ensure they worked effectively. Systems and processes were not consistently in place to monitor and assess the quality of service that people received. There was evidence to show that the care co-ordinator regularly audited daily notes and MAR records for accuracy, completeness and quality. There were no audits undertaken of documents related to people's care or staff records. This meant that areas where records were inaccurate or issues recognised as requiring improvement were missed. This included documentation that was missing or had not been reviewed within relevant time scales. An example of this was for a person who had been identified as someone at high risk of falls. The falls risk assessment identified that as a high risk and that the assessment should be reviewed monthly; however documentation showed that this had not been reviewed since July 2017.

People's support documentation lacked consistency. The registered manager had not identified set templates to use and therefore each care plan contained a combination of previous provider paperwork and new documents. This made reading and understanding information about people, difficult. Some information in care plans also lacked consistency, for example in one part of a person's file, it stated they independently administered their own medicines and in another, that they needed support. There was also a lack of consistency between care plans in the office and those kept in people's homes. An example of this

was a mental capacity assessment completed by a social worker regarding the use of mobile telecare. This equipment ensured that the person could still independently use local facilities and amenities and be located if they became lost. It included a map of the area and a list of places that the person may choose to go if the person did not take equipment with them. This information was in the main office file but not in their home file which meant that staff would be unable to access it if they arrived at the person's home and they were not there.

It was evident from speaking with the registered manager, care co-ordinator and staff, that they knew people and their support needs well. However information was not always reflected in care documentation. An example of this was for a person who could display behaviours that challenged. There was limited information about what the behaviours were, any triggers that could cause behaviour or how the person should be supported during this time. In one person's home file we saw that staff were using a chart to note when there had been behaviours that challenged; however there were no systems to ensure this was monitored or reviewed and therefore patterns or trends in behaviour were not being identified. If staff who were not familiar with the person were to read the support plan, they would not have sufficient information on how to support the person should they display behaviours that challenged and this could place the person and staff at risk of harm.

Although staff demonstrated understanding of a person's needs with regard to medicines given covertly, there was no other guidance regarding their covert medicines. A more detailed assessment was required for why medicine was covertly administered, how this benefitted the person, views from others involved with the person's care and how the person should be supported consistently by staff.

There were no protocols for PRN medicines and so staff did not have guidelines as to when they may be required. Staff did not always record whether the PRN medicine when given, was effective. Staff providing regular support to people knew support needs however it was acknowledged by the registered manager that if unfamiliar staff were to support, they would not have the information that they required to support. We therefore recommend that the provider considers current guidance on 'as and when required' medicines and takes action to update their practice accordingly.

The registered manager and staff were able to tell us which people had sensory or communication needs and how they were supported; therefore there was minimal impact on people. However, this was not consistently evidenced in people's care plans, which meant unfamiliar carers would not have the information they needed to support people. In some, sensory or communication needs were not mentioned until the end of the support plan. These guidelines were not in line with the Accessible Information Standard(AIS) This standard applies to people who have communication needs relating to a disability, impairment or sensory loss and identifies steps that providers should follow to ensure these needs are identified, recorded and met appropriately.

People told us that they had regular contact with the agency and that during reviews, they expressed any concerns or issues in satisfactory surveys. However there was no further evidence to show that the registered manager had sought feedback from others to continuously improve the service provided. We discussed this with the registered manager and they advised that they would use questionnaires to seek feedback from people, relatives, staff and other stakeholders. This will also give them over-view of any patterns or trends.

The provider had not ensured good governance had been maintained. Therefore, the above areas are a breach of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff informed us that they received a robust induction programme, there was no evidence in staff files to demonstrate this had happened. We were told that this was available on another system but due to technical difficulties, we were not able to view this on the day of inspection. The registered manager advised they would ensure that information related to induction was transferred to staff files.

Staff told us that they attended regular staff meetings where they discussed any issues with people they supported or other concerns that they had. Staff meeting minutes were reviewed and showed that staff met regularly and an agenda was set for items to discuss. There were also management meetings held that focused on the business and its development.

Spot checks were carried out on staff by the Care Co-ordinator regularly. These assessments monitored whether the staff member arrived on time, whether they met all care needs and how they interacted with the person. Feedback was then given about positive work practise or areas for improvement.

The registered manager ensured that they remained up to date with current legislation and practise by attending regular training. They were in the process of completing a 'train for the trainer' course which meant that they could support staff directly with learning.

During inspection, we found the registered manager to be open and transparent. They were aware of areas that still required improvement and discussed actions they were going to take to rectify this. Issues that were identified on inspection were reflected upon by the registered manager and care co-ordinator. This demonstrated a willingness to improve.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained. Appropriate systems and processes were not in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1) (2a) (2b) (2c)