HH Community Care Limited

Helping Hands Community Care - Blyth

Inspection report

79 Bridge Street
Blyth
Northumberland
NE24 2AN

Tel: 01670797946
Website: www.helphands.co.uk/

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

Summary of findings

Overall summary

We last inspected this service in March 2015 where we found the provider was not meeting Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to governance of the service. The provider sent us an action plan of how they were going to address these issues. At this inspection we found that concerns remained in relation to Regulation 17 and we found other areas of concern.

This announced inspection took place on 30 and 31 January and 1, 3 and 7 February 2017. The inspection was announced so we could be sure that staff would be available in the office, as it is a domiciliary care service, and to allow that people who used the service to be informed that an inspection was underway. We planned this inspection to follow up on the breach at the last inspection. We subsequently decided to complete a full comprehensive inspection of this service because there had been a number of concerns raised regarding the providers other service and we wanted to confirm that the same issues were not replicated at Helping Hands Community Care - Blyth.

Helping Hands Community Care - Blyth provides personal care and support to people within their own homes or the community across the whole of Northumberland. At the time of our inspection over 900 people were active on the service's register with 415 staff members employed to provide various forms of care and support.

A range of people used the service including older people, young adults, children, those people with complex care needs, those with a mental health condition and those with learning disabilities. Staff supported people with a variety of care packages, ranging from shopping and sitting services to 24 hour support which included personal care, meal preparation and administration of medicines. The service also offered an enablement service. This means staff support people to do tasks they would not normally be able to do without support. For example, going out to the shop or visiting friends or family members.

The service had a manager in post who had started the process to apply to become 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. The provider had recently appointed a new managing director and a new nominated individual. A nominated individual has responsibility for supervising the way that the regulated activity is managed. They should be an employed director, manager or secretary of the organisation.

The provider had failed to fully meet the requirement notice relating to the previous breach of Regulation 17, good governance.

Medicines management needed to be improved. For example, staff had not always fully recorded administration of people's medicines and this made it unclear if people had received their medicines on

time and as prescribed. The provider had started to make some improvements in this area.

People's records were not always up to date or relevant, including care plans and risk assessments and capacity assessments. Reviews of people's care records had taken place. There were no robust quality monitoring checks in place for care records, medicines procedure or full health and safety within the service. We also found policy and procedures were not always in date or in place.

People were encouraged to make their own decisions and had choice in what they wanted to do. A record of a person's capacity was made available from the local authority if the person was contracted through them. However, the service had not routinely assessed people's capacity or what that meant for care staff, particularly those privately funded.

The service had not routinely asked for details of lasting powers of attorney or if a person was under the Court of Protection. This meant details may have been missing which were needed to make a best interests decision and ensure the correct people were involved.

People and their relatives told us they felt safe with the service offered. Staff were able to describe correctly what actions they would take if they suspected any abuse occurring.

There was enough staff to provide cover to all of the people who received care and support from the service. However, we have recommended that the provider review scheduling rotas and staff travel arrangements to ensure enough time was allocated for care delivery and to maintain staff welfare.

The provider was rolling out a new training programme to ensure staff were up to date with best practice.

Staff told us they felt supported. Supervision and appraisal systems were in place, although there was not a consistent approach and records were not always in place. Staff meetings took place. We have made a recommendation that all meetings are recorded.

People who received support with meals and drinks told us staff supported them well and helped them to maintain their nutrition and hydration levels, including offering them choice in the support they received. People who were supported with activities as part of their care package confirmed staff helped them to remain socially connected.

People who required additional support from other healthcare professionals, for example GP's, were supported by staff to arrange this.

People and their families were complimentary about the kind and caring nature of the staff who supported them. They confirmed that dignity was maintained and staff respected them as individuals.

People knew how to complain and we found staff had dealt with any complaint received appropriately and within suitable timescales.

We found two breaches of Regulations with regard to Regulation 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not sent notifications to the Commission which are a legal requirement of their registration regarding, for example, notifications of change to the registered manager. That meant they were in breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely, although the provider was in the process of improving this.

Risk assessments and accident recording was not robust.

People told us they felt safe and their relatives supported these comments.

Staff were aware of what constituted a safeguarding concern and told us they would report any issues they had about people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity had not always been assessed by the provider and best interest decisions were not always recorded.

Staff felt supported, although there was not a consistent approach.

Staff were in the process of receiving a new training programme which the provider had out sourced.

People received food and drink which met their nutritional needs and staff supported people with any additional healthcare needs, including appointments to hospitals or visits to the GP.

Is the service caring?

Good

The service was caring.

People said staff were kind and caring. Many people had been with the service for many years and knew staff well.

People told us that staff supported them to maintain their independence and respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were in the process of being updated and replaced which included more detail and information about the person who used the service.

People told us they were involved in their care and received regular reviews.

People were encouraged to keep in touch with family and friends and avoid social isolations.

Is the service well-led?

Requires Improvement

The service was not always well led.

A robust quality assurance system was not in place, although some improvements had been made.

A new manager had been appointed at the service. There was also a new managing director of the organisation and a newly appointed nominated individual to represent the provider.

The provider had sent in notifications as legally required, but had failed to tell us about a change to the registered manager position.

Policies and procedures were in place but needed to be updated to provide staff with accurate information and guidance to help them support people appropriately.

Helping Hands Community Care - Blyth

Detailed findings

Background to this inspection

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

This inspection took place on 30, 31 January and 1,3 and 7 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office when we called and also to give prior warning and arrange visits to people using the service. The inspection was carried out by one inspector, one pharmacist inspector, two experts by experience and one specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had a background in nursing.

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 other information we held about the service, including the notifications we had received from the provider about safeguarding concerns, serious injuries and deaths. We also contacted the local authority commissioners for the service, the local authority safeguarding team and the local Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection.

We visited 16 people who used the service in their own homes and spoke over the telephone with a further 19. We also spoke with 20 family/carers of these people. We spoke with the manager, the nominated individual, the managing director, four team managers, four scheduling officers, one administrator and 28

care staff. We attended a care staff team meeting. General observations of how care staff interacted with people was undertaken during visits to people's homes when care staff were present.

We looked at a range of records which included the care and medicines records for 25 people who used the service, seven staff personnel files and other documents relating to the management of the service, including policies and procedures.

We contacted two district nurses during the inspection process and two local GP's. Where we received responses, we used these to support our judgement of the service.

After the inspection we contacted the Clinical Commissioning Group to share information and spoke with care management to pass on further information. This was all in relation to enhancing procedures in connection medicines management.

Requires Improvement

Is the service safe?

Our findings

The majority of people we spoke with told us that staff supported them with their medicines in a timely manner. Comments included, "They [care staff] always prompt and check I have taken my medication"; "They [care staff] always check that I have taken the medication. They a good"; "I have a bad memory. They [care staff] always put the medicine out for me…..they always check I have taken them" and "I can't take the medication on my own. They [care staff] always give it to me…they are marvellous."

However, there had been issues with people's medicines, including medicines which had gone missing and people who had missed or been given incorrect dosages or had medicines administered at the wrong time. Most of these concerns had been sent to us via notifications received from the provider. For example one person had not received their warfarin as prescribed while another person had received too much. These had been investigated; however, we found a range of concerns in connection with the mismanagement of medicines still had occurred.

We asked about people's medicines which needed to be taken before food, for example Alendronic Acid. The manager said it would be given at the start of the care visit and staff would then give the rest of the medicines after a suitable time (usually half hour) had lapsed. We checked records for a number of people who took this type of medicine. Records confirmed that staff could have followed the manager's statement to us because, for example, one person had a half an hour call at the correct time. However, when we looked at the person's medicines records we were unable to establish if they had been administered their medicines correctly as medicines were recorded together after a meal had been taken. Furthermore, the person's records did not indicate this medicine needed to be taken at specific times or the risks involved. This meant we could not be sure people had received their prescribed medicines at the correct times, or as directed.

Staff supported some people with the application of topical medicines as part of their care regime. Topical medicines refer to applications to the body of a selection of, for example, creams and ointments. The manager said that staff administered this type of medicines from information printed on the label. They also told us that it was the intention of the provider to start using body maps to show staff where medicine was to be applied. In one person's records it was recorded they required support applying cream, however it did not state the frequency, which meant the person may not have received the support they required.

People's medicine records, including care plans and risk assessments were not completed fully or accurately and it was unclear whether medicines had been administered or prompted with people. One person's medicines record stated, "2 tablets prompted from dosette boxes" (other records for the same person indicated this medicine had been administered). Another person's records showed medicines had been left out when care plans and risk assessments did not indicate this should occur. One staff member told us, "Care plans from the local authority have it written that clients are prompted when they are administered their medicines by staff. It can cause some confusion." We spoke with one of the line managers from the care management teams who produced these care plans and they said they had raised the issue

and were going to take our comments forward.

The provider had recently made changes to the way staff recorded people's medicines in their homes and were starting to use medicines administration records (MAR) produced by the chemist and had recently started to implement a new medicines risk assessment process and a new training programme for staff. This meant the provider had started to make improvements to the way medicines were managed which would lessen the risk of errors occurring.

We found there were regularly reviewed risk assessments in place for care staff to be able to work in people's homes safely. Risk assessments had also been completed for example, in relation to supporting people with personal care, dressing or other specific tasks but had not been put in place for all issues. We also found that the risk assessments were basic and did not include particular action for staff to take in events such as an accident occurring, medicines given at the incorrect times or in connection with particular behaviours which may have challenged the service.

Accidents and incidents were recorded on the providers IT system and staff passed on information to the office staff to log any events. We found when staff reported events, that these were not always followed up with outcomes. Weekly meetings had been recently implemented to discuss accidents and incidents to monitor for trends forming and look for ways to further mitigate any future issues.

These were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to safe care and treatment.

People's comments about how safe they felt included, "Absolutely safe"; "Oh yes indeed"; "Yes, very much so"; "Yes, I have known them for years. I feel very comfortable"; "Very pleased to see them [care staff] no issues of safety"; "My daughter has no worries now"; "Oh yes I feel very secure" and "Very much so… put it this way I would say, I am up front that way. I have rung them and told them I am more than happy."

Relatives felt that their family members were safe and comments included, "Ah I think so, I don't interfere and am quite happy with it (care)" and "Indeed, Indeed wonderful girls [care staff]." There was one issue raised by a relative which we addressed with the team manager and saw that actions had been taken.

Where concerns of a safeguarding nature had been raised, the provider had taken action, which in some circumstances had included disciplinary action. The new managing director and nominated individual were proactive in ensuring that safeguarding remained high on their agenda and had incorporated additional safeguarding training into the new programme of learning staff were currently taking.

Staff were able to describe the action they would take should they have any concerns regarding a person's welfare or safety. We were satisfied from the conversations we had with staff and people, that people were safe and staff would report any concerns they had. The provider had recently updated their safeguarding policy to ensure staff had information to guide them in line with best practice.

During phone calls and visits to people in their homes, we were told that the majority of care staff attended on time, completed allocated care or support tasks and remained for their specified time. In some cases we were given evidence that care staff went over their allocated timeslots. For example, one person told us, "There was, in the past, an issue with one care worker who came late. I spoke to the office and this care worker does not come anymore. Odd times they [care staff] may go before the time finishes but this is because they have completed the tasks and they always ask if there is anything else to do. They tell me they will be passing the shop in the morning and if there is anything I need they go above and beyond what they

are expected to do."

Other comments from people included, "Yes my care worker is always on time. They complete all the tasks they need to for me"; "They [care staff] have never been late for me. They complete the entire task and they stay longer than is required"; "They [care staff] are never late. They only come late when I tell them to… if I have an appointment" and "They are very rarely late…on odd occasions we have one care worker who turns up instead of two. This is because the other one is poorly. I am not really fussed as I will help the care worker to assist my relative. This has only (I stress) happened on odd occasions. If they are late it is 10/20 minutes (which they felt was acceptable on the odd occasion)." One relative commented, "Several years and there have been no missed visits."

However, a number of people and relatives commented that care staff were "frazzled", "worn ragged" and "pushed too much between visits." One person commented, "They do need to look at the rotas. They [office staff] have the girls [care staff] travelling from one side to the other….these girls travel on bike and it's impossible to be in two places at the same time. The rotas do not take into consideration the travel time." People and relatives also told us that despite care staff being asked to provide care in two places at the same time, and the pressures this placed them under, this had not compromised the way they provided care and support. Out of 11 care staff that we asked about their working day they all felt they did not have enough time in between visits. We asked if there was any occasion of this leading to unsafe practice and they all said no. Staff went on to tell us that if they needed to run late to provide additional care to keep people safe, there was never a problem.

We recommend that the provider reviews scheduling of staff rotas to ensure staff have enough time to travel between visits.

Due to the nature of the service and the number of people provided with care and support, we were aware that at times people were not always able to have the same care staff. This was due to sickness and absence in the main. People's comments in relation to this were varied and included, "I have a fantastic carer who comes all the time. It's only when they are on holiday…..but the care continues. I have no problem with this"; "99% same two carers….only have new ones when these are on holiday. I have no issue with this" and "Mostly different care workers. I cannot grumble." Relatives had mixed views on the continuity of care staff and told us, "My relative has 16/17 different care workers each week…this is too much change for them"; "It's normally the same one's [care staff]" and "We occasionally have new care workers but have no problem with this."

We were made aware of a number of staff who had accidently missed the calls from their rotas for a number of reasons, including not receiving the updated rota or forgetting to attend. The provider told us they were currently looking at investing in a new system to improve monitoring care calls and enhance staff safety while lone working.

Each person we visited had contact details for the provider and the on call number which could be accessed out of hours. Also recorded were GP's numbers and other numbers important to the person's care, including any next of kin or family details.

Some people who used the service told us that staff supported them with shopping. One person explained the correct procedure which staff would follow in connection with any financial transactions which took place. This included keeping receipts and recording all expenditure. The person went on to say, "What they do is…. they have a file left in my house and fill it in each week and ask me to sign."

Staff were provided with work mobiles to keep in touch with the office and to ring ahead if they were delayed. We were also informed that these phones were used as a safety measure in case of emergency and the need to contact emergency services was required. The provider had issued staff with personal safety alarms and on call emergency numbers for staff to use should they need additional help.

Staff recruitment documentation was held centrally at the provider's head office in Stocksfield. At our inspection in November we checked recruitment procedures and found them to be in line with safe practice. The provider told us that they had recently employed a person to head their human resource (HR) function and they were in the process of updating and further improving this area of the business.

Requires Improvement

Is the service effective?

Our findings

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. Staff had been provided with an overview of the Mental Capacity Act 2005 (MCA) during their induction. We also saw that a number of staff had completed Deprivation of Liberty Safeguards training (DoLS). DoLS is not applicable in this type of service. The provider would ensure referral to the Court of Protection was made via the local authority with any concerns relating to a person's capacity in order to keep them safe from harm. Management confirmed that no person had been referred to the Court of Protection.

We saw examples recorded in daily care records where staff had conferred with relatives or health care professionals when a decision needed to be made for people who lacked capacity. It was not always clear from the person's records how staff had established the person lacked capacity or how the best interests decision had been made and by whom, although we saw in some cases that information had been provided by the local authority. We discussed this with the provider and they confirmed that no mental capacity assessments were completed by them and no best interests decisions were recorded separately for some people. We were not able to establish if people had a Lasting Power of Attorney (LPA) or if they were subject to a Court of Protection order because the provider had not routinely asked this question during the assessment process or recorded these details as a matter of course in people's records. Although we saw no evidence to show staff were, it meant they may not have acted in the best interests of the person because the provider had no relevant paperwork in place to record this. Policies were also in the process of being reviewed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to good governance.

People felt that care staff were mostly well trained and effective in providing them with the care and support they needed. They told us, "They are fantastic and certainly know what they are doing"; "On rare occasions I will have a trainee. They come in pair's but this does not affect my care" and "The company used to look after my relative and now it's me. They understand me…they look after me." One person, however commented, "On occasions, the new ones… I have to explain what I need doing but I suppose we all have to learn."

We reviewed 10 records of newly appointed staff. There was clear evidence staff had completed a full induction in line with The Care Certificate. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe and compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards. One staff member told us they had completed a full induction programme and also said, "When I started, I could shadow another member of staff for 3 weeks." Staff confirmed that they had undertaken a

range of training and were about to embark on further new and updated training. One staff member told us they had received a range of training, including, "moving and handling and use of equipment, giving medication, managing challenging behaviour, documentation and dealing with concerns and complaints." Other comments from staff regarding training included, "I feel I am getting enough training"; "I enjoy doing the job. I have been on a full induction course. Also, received bereavement training and medication training"; "I have had training… medication, safeguarding, mental capacity."

One person confirmed care staff were trained specifically to help them transfer using specialist equipment. They told us, "Carers know how to use the hoist and slings safely. There have been no accidents…they do it well." One relative confirmed that the provider had responded positively by providing care staff with specific training which was required to help them care and support their family member more effectively. One member of care staff told us they had asked for some special moving and handling training. They said their manager had organised this for them. A new training programme was in the process of being rolled out across the staff teams in order to address shortfalls in care delivery. This included, for example, medicines management and the need to read and understand care plans and other related paperwork.

Staff had a good understanding of their roles and responsibilities, including care and office staff. One member of care staff told us they understood their role when they attended a person's home and felt that care plans gave them enough information to do their job. Other staff recognised that changes had been planned and were in the process of being implemented. One member of care staff said, "I know there is a new person in charge and we are putting new training and paperwork in place…..it can only be good."

We saw evidence, or were informed by people or their relatives that staff had acted very well on occasions when either an accident or incident had occurred. When we visited one person we were made aware through conversation and looking at records of an occasion when they had fallen. We were made aware that the staff member had dealt with the situation well on finding the person, including keeping them comfortable until help arrived. A relative told us of an incident which had occurred when staff were out in the community supporting their family member. They told us the staff member "had managed extremely well."

One relative explained the office staff were good at matching care staff to their family member's specific needs. They told us there was a stable team of care staff and they were "impressed how the office have matched the carers with different abilities" to their family member. We were told this had ensured more effective care and support could be offered.

Although we were not made aware of any person coming to any harm because of this, a number of people and their relatives told us that communication was not always as good as it should have been. A person gave us an example of poor communication when medicine administration records had arrived and they had not been told about them or what they were for. One relative said they often left notes for the care staff but did not feel confident that staff would read them and had examples of where this had happened. Another relative told us they didn't always get messages from the office as staff forgot to pass them on.

A further relative gave us examples of when care staff had not read care plans and other related records which meant they missed some key information about the person's preferences. One relative told us that care staff often did not read the handover information which meant they were concerned "things" would be missed. We spoke with the nominated individual, managing director and manager about this and they told us that all staff were required to read all of the documentation in people's care files, including daily notes, and said they would look into this.

Staff said they felt supported by the organisation and enjoyed working for them. We overheard conversations as staff met with team managers in the team offices within the provider's premises. We heard them being supported appropriately with issues they had brought for discussion.

Copies of staff records showed that supervision was not consistent. Some staff had informal support sessions with staff every five to six months and in other services it was annually. The manager told us that there was no supervision policy in place, however, the provider told us this was in the process of being updated and showed us a review of policies template which they were working on to confirm this. Annual reviews were carried out and the provider was in the process of working through these. This meant that although staff told us they felt supported there was not a consistent approach and records were not always in place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to good governance.

From people's records we saw that when they needed support from healthcare professionals, for example, GP's or hospitals; staff had supported them. One person told us of an incident when they had contacted their GP who they thought had not listened to them. They told us a member of care staff had then contacted the GP on their behalf and on examination were found to need treatment for a specific ailment which was identified. Another person told us, "I see GP's when I need to. [Named care staff] will help me to call if I need them to."

People told us they were satisfied with the level of support the care staff provided them in respect of their needs regarding nutrition and hydration. One person told us that care staff always asked them what they wanted during meal time preparations. They said if they could not think of anything; staff would make suggestions. They also told us that staff would monitor their fridge to ensure food was still edible and that they had enough. One relative told us that their family member was diabetic and staff monitored their levels of eating and drinking to ensure they remained safe. Through viewing people's records and by talking with people, their family and staff we confirmed that people were supported appropriately with their food and refreshment needs.

Good

Is the service caring?

Our findings

Many of the people we spoke with had used the service several years and told us they knew staff well. Both people and their relatives were complimentary about the care staff who supported them. Comments from people included, "I can't praise them enough and couldn't do without them. Just to be able to air things, that's great"; "Oh she [member of care staff] is a gem, she is really just so caring and it shines through"; "I really look forward to them coming "; "Oh yes. The care workers are top of the class"; "They are all local care workers who live nearby. I know them well"; "Absolutely perfect. The care worker is always happy singing along….really makes me happy. I really look forward to my care worker coming to see me"; They are very good. We can have a laugh…something I really look forward to is my care worker coming"; "I cannot fault any of the care workers…caring, kind and wonderful people" and "Oh yes definitely.....we always have good conversations and they are always friendly."

Relatives thought the care staff were kind and caring. Comments included, "Carers are very patient and kind"; "There is a handful of care workers who are absolutely fabulous"; Always great to my relative…great to see they chat with my relative"; "Excellent…..[one particular member of care staff] goes over and above what you expect" and "They [care staff] know them [person] well, they like singing and they sing away." One particular relative told us their family member can be "awkward" due to their condition; however they said, "Carers were patient and take their time when providing care."

People told us they felt involved with the planning and review of their care needs and told us, "Yes the girls and office always update my plan. They always discuss this with me"; "I get visits from managers every now and again…but don't ask me how often because I cannot remember. They come and check everything is okay and that nothing needs changed."

People we spoke with thought that staff respected them and helped them to retain their dignity. One person told us, "Very helpful…always gives me respect & dignity." A relative told us, "They always respect my relative…kind and caring. My relative laughs with the care workers which gives me such comfort." We overheard staff in various offices within the provider's premises responded to phone calls from people who used the service in a sensitive and polite manner.

People were supported to remain independent. One person told us staff supported them to make decisions in connection with their daily lives. They said, "We have a talk about what I would like to do. This keeps me in control of what happens, which is how I want it."

We saw evidence on the provider's electronic IT system that advocates had been used for some people who used the service. People we checked had friends or family to support them with any issues they may have needed additional help with. Staff at the service were aware of how to access advocates if the need ever arose. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. This meant that if people needed the support from this type of service, staff would be able to support them to find an appropriate service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the provider had not always maintained up to date care records and found that they were in breach of Regulation 17. We issued them with a requirement notice to take action to address this. When we returned to check that actions had been taken, we found that although some improvements had been made, there were still issues to address.

A referral form was completed for people who were planning to take up the service. This form asked key questions about the person and their history. This form was then used to build a care plan and preferences centred around the person's individual needs, including likes and dislikes. We found the documentation used did not include specific questions or detail, for example, in connection with people's mental capacity or it lacked some of the detail required to ensure people's preferences were met in a way they wanted them to be. For example, we were told after a visit to one person that their family should be contacted in the first instance, but when we checked their records this was not recorded and furthermore the person had full capacity. Another person's care plan stated that they were supported with showering and personal care but there were no preferences completed as to how the person liked this support to take place. Overall, it was not clear from the records we saw that the provider had fully assessed or planned people's care and support to meet each individual's needs.

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

The provider confirmed that they were in the process of implementing a new range of paperwork to address these concerns.

People received an initial review after staff had worked with them for a number of weeks and then six monthly checks thereafter. One person told us, "Someone came out not very long ago to ask for feedback." People and their relatives confirmed that staff reviewed the care they received regularly, either by telephone or by visiting them in their own homes. One person told us, "If there are changes to the care plan, this is done pretty quickly." One relative told us, "Yes, someone has been and reviewed what the staff do for [person's name]. They changed what they do in a morning as [person's name] health has declined and it has made a big difference." This confirmed that people had been involved and staff had changed the way people were supported when changes were identified.

People were given a choice. They told us, "The girls [care staff] always ask me what I want for breakfast; they would never do anything without asking me first what I wanted to have"; "Staff are very good like that, always ask first" and "I get asked if I would like this or that…you know what I mean….they ask me what I prefer not what they want to do!"

A number of people who used the service had support with activities as part of their care package. One relative told us that care staff, "Suggest suitable activities for [person] to participate in when they go out." They went on to tell us that their relative was supported to access a range of community venues to stop

them from becoming socially isolated. A person told us that with the help of the staff they were able to visit the local shops, which was really important to them. Another person told us that staff supported them to access online facilities, which helped them to keep in touch with friends and family.

At the inspection we reviewed the complaints procedure. People and their relatives told us they knew how to complain if they felt they needed to. Comments included, "I never had to make a complaint…I have the numbers if I need to"; "They try their best. I have no complaints." One relative gave us a specific example of a care worker who had not respected the person they were looking after, or the family, as well as they should have. They told us they had complained and it had been dealt with immediately.

The provider had sent us information about the service prior to our visit called a provider information return (PIR). In this document it stated that there had been two complaints made within the last 12 months when it was completed in October 2016. We found 64 complaints logged on the providers IT system. They had been dealt with appropriately and in line with their current policy which was in the process of being updated. All senior staff advised they took complaints seriously and said they liked to resolve them promptly. One team manager told us, "I always like to respond immediately. It is important to us. I always visit as soon as the complaint comes in, if appropriate; sometimes on the day of the complaint." The team manager demonstrated how they had responded to three complaints and what actions had been taken, which were all appropriate to address the concern.

Requires Improvement

Is the service well-led?

Our findings

Archived care records were found in a training room which was accessed by a range of staff and was not locked. Although the building itself was only accessed by prior approval from administration staff, the unsecure storage of records was discussed with the manager and nominated individual and they said that they would address our concerns.

People's records held in their homes, including daily records and medicine recording sheets were removed in an ad hoc manner and returned to the office. The provider had no written guidance asking staff to return completed care records back to the office, for example, after a month was completed. This meant that some people's archived notes were at the office and some were not. People's care records, including care plans, risk assessments and medicine records were not always accurate or up to date.

While visiting people's in their homes we saw staff signing in and out when they attended. However, we noted staff were signing at the time they were meant to have left as opposed to the time they actually left in some cases. We brought this to the attention of the provider who said they would look into this issue. People's care records are important documents and should be accurately recorded.

When we viewed the provider's manual for policies and procedures, we found there was no policy for supervision. The manager and Nominated Individual told us there was no supervision policy for the service and had never been one. Other policies were out of date, such as manual handling policy. Policies should be regularly updated to ensure they are current and comply with legislation. We were already aware that the provider was in the process of updating all of their policies as most were out of date or there were no identified policies in place.

Team managers from across both of the provider's services met weekly to discuss any accidents or incidents and this meeting was chaired by the Nominated Individual. We saw minutes of these meetings and were told these had been implemented after the inspection at the provider's other service in an attempt to improve governance. Team managers told us they found the meetings beneficial as it was a way of coming together as a "whole" team and "sharing best practice and ensuring that issues have been dealt with properly."

Separate surveys had not been sent out to people who used the service. However, views were gathered through regular review visits, with any actions taken, although these were not analysed separately by the provider to look for any trends. One person told us, "Someone from the agency recently visited to gather feedback."

Overall, the provider had made some improvements to monitoring the quality of the service, but had not found the issues which we uncovered during our inspection. We found no robust audits on care records, medicine administration or monitoring of health and safety issues at the service, to ensure that people consistently remained safe and received a good quality service.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. In relation to good governance.

We noted in a newsletter sent to staff in April 2016 that the registered manager had announced their pending retirement in September of the same year. The provider had failed to send us a notification of change to the service in respect of the retirement of the registered manager.

This is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

The service had a newly appointed manager. They were in the process of applying to the Commission to become registered once their DBS checks had been received. They had worked for the organisation for over 20 years. The manager was in attendance throughout the inspection and provided us with all requested items throughout our visit.

People and their relatives felt that the service was well led. Comments included, "Very good indeed.. the head of the company does come out to see me"; "The girls [care staff] are great. The company is great"; "Quite well ran" and "Yes well it's a new period…new structures… big changes for the company. It's a good change I feel."

One person who had used a number of other agencies told us that they thought this was the best one. Another person was very happy with the service and told us they would "recommend the agency to anyone else."

One staff member said no regular staff meetings took place, however all of the other staff we spoke with confirmed there were regular meetings for staff to attend. We attended a staff meeting, although the team manager told us these were not mandatory. Minutes were not taken as the meeting was informal and acted as an opportunity for staff to discuss any issues they had and collect any personal protective equipment (gloves and aprons for example).

We recommend that any meetings which take place are recorded.

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 15 Registration Regulations 2009 Notifications – notices of change The provider had not informed us of the intended retirement of the registered manager. 15 (1)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely or in line with good practice. People were not fully protected because the provider had not always assessed and mitigated risks. Accidents were not always fully recorded or monitored and risk assessments were not always completed or reviewed. 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust quality assurance system in place to monitor the service provided, including monitoring risk. The provider did not always maintain up to date records or keep people's records secure. The provider did not have a full range of up to date policies or procedures in place.