Life and Care Solutions Limited

Right at Home Tyneside

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

Summary of findings

Overall summary

We carried out an announced inspection of this service on 3, 4 and 17 July 2017.

At the last inspection in June 2015 the provider was meeting all of the regulations and had an overall rating of good.

Right at Home Tyneside provides personal care to people in their homes across Newcastle, North Tyneside, Gateshead and Northumberland. The service is based in South Gosforth and provides general care but also specialises in supporting people with complex health needs and palliative care, including supporting people who are living with dementia. The service can also provide companionship and an enabling service to support people with daily tasks, for example, shopping or visiting the hairdressers. At the time of our inspection there were 47 people using the service, some of whom were receiving 24 hour care. Right at home Tyneside is a franchise of the organisation 'Right at Home'.

The service did not have a registered manager in post. 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.

A new manager had been appointed at the end of 2016 and was in the process of applying to become registered. There had been a delay in their application and we are dealing with this outside of the inspection process.

People told us they felt safe and comfortable with the care workers who visited their homes. Policies and procedures were in place to safeguard people from harm or abuse and staff understood their responsibilities. Records were kept regarding safeguarding concerns and investigations had taken place in a timely manner. The provider had reported all incidents of a safeguarding nature to the local authority safeguarding team but had not always notified the Commission.

Medicines were administered by staff who had been trained to do so, however, we found issues with the management of medicines which needed to be addressed.

Risk assessments were in place and individual needs had been assessed with control measures put in place. However, records were in need of review to ensure they still mitigated all risk. Not every person had a current care plan in place, although the provider was in the process of updating these.

The provider's recruitment processes were not robust which had meant some issues in vetting had not been addressed appropriately. This meant people were put at potential risk unnecessarily.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service support this practice. We have made a recommendation about reviewing care records to ensure this is adequately demonstrated.

People were supported to maintain a balanced diet. People told us care staff made them meals they preferred. One relative told us that their family member had put weight on since starting to use the service. We confirmed staff had undertaken training to support them with people's nutritional and hydration needs. We observed appropriate meals being prepared to support people with particular dietary needs.

Most staff felt supported by the provider and management team, though a number of staff felt unsupported and undervalued. They said that communication had been poor, but that this was gradually improving. More staff meetings were being held and the provider and manager were in the process of ensuring that all staff received regular support sessions. This included annual appraisals as these had not been provided as they should have been.

Staff received a range of training to support them in ensuring that people's needs were met.

From observations, staff displayed caring and compassionate attitudes and people told us that care staff were kind, caring and often went the extra mile for them.

The manager held information relating to complaints, accidents and incidents. There was a complaints policy in place and evidence showed complaints had been dealt with appropriately and in a timely manner. People told us they knew how to make a complaint and would have no hesitation in contacting the provider or manager should they need to.

The provider monitored the quality of the service. However, they had not always identified the issues we found during our inspection, including for example, with medicines and staffing records.

Most people spoke highly of the provider, the manager, office and care staff who supported them to live at home. However, a small number of relatives pointed out that as the organisation had grown, it had become stretched and did not feel as good as it once had. The provider was aware of their limitations and had recently introduced new roles to support the running of the service, including a human resource and a new training lead. There was a constant recruitment process in place to ensure the service had enough staff to meet the needs of people. The provider was passionate about providing quality care as was the new manager.

We found four breaches of regulations relating to safe care and treatment, fit and proper person's employed, staffing and governance. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines management needed to be improved.

Safeguarding procedures were being followed correctly however, concern had not always been reported to the Commission.

Risk assessments were in place but were in need of review.

Staff recruitment was not fully robust and needed to be improved. Staffing capacity continued to be improved on.

People told us they felt safe when being provided with support by care staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent to care and treatment was sought in relation to people's care and treatment. However, record keeping was not always in place to reflect this.

Staff were inducted and trained in a variety of subjects. They were supported by the management team through supervision, appraisal and team meetings. However, not all staff had received support as they should have.

People's general healthcare needs were met and the service involved other health professionals when appropriate.

People were supported with their meals and refreshments where this was part of their care package.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and friendly with caring attitudes. They understood people's needs and responded to these.

People told us that all staff treated them with dignity and respect and that they were treated as individuals.

People were involved in making decisions about their daily care and support. Staff encouraged independence where this was possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Person centred care plans were in place but not all had been updated or reviewed regularly.

People were supported with activities to help meet their social needs where this formed part of their care service.

A complaints policy was in place and people were aware of how to complain. Complaints had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in place but a new manager had been appointed. The atmosphere in the office was positive.

A set of audits were in place but needed to be reviewed to ensure robust procedures and standards were maintained.

Feedback was sought from people and their relatives to gauge their satisfaction with the service.

Staff meetings took place. Most staff felt supported and valued in their role but not all.

Right at Home Tyneside

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 the 3, 4 and 17 July 2017 and was announced. We gave the service 48 hours' notice of the inspection because it is a domiciliary care provider and we needed to ensure that someone would be in the office on the first day of our inspection.

One inspector and an expert by experience conducted this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about the service, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In addition, we contacted the local authorities monitoring teams and adult safeguarding teams to obtain their feedback about the service. Where we received a response, we used this information in the planning of the inspection.

The provider had completed a Provider Information Return (PIR) prior to the inspection. A PIR 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 used this document to help plan our inspection.

As part of the inspection we visited four people in their own homes and spoke to a further six by telephone. We spoke with eleven people's relatives to gather their views about the service. We also contacted ten people or their relatives by email.

We spoke with the nominated individual, the manager, the deputy manager, two team leaders and seven care staff. We contacted two social workers, a district nurse and a GP and where we received responses, we used their comments to support our judgements.

We reviewed seven people's care and medicine records and other records relating to the management of the service. This included five staff files, the electronic roistering system and records relating to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Recruitment procedures were not as robust as they should have been. Staff files contained information which showed staff were not always recruited safely. There was evidence of employment history, pre-employment vetting checks including enhanced Disclosure and Barring Service (DBS) checks and references from previous employers. These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However, we found two instances where issues raised during the vetting process had not been dealt with appropriately. For example no discussion was recorded with the staff members regarding discrepancies on their DBS. No risk assessments had been completed to confirm if the staff members were suitable to work with vulnerable people or if they needed additional support or monitoring.

Staff members had DBS first checks completed, which checked if staff were listed on the barring register. If this was clear, staff were deployed and supervised at all times. We spoke with the provider about our findings. They told us they were in the process of changing procedures, including having final sign off of all staff employed and ensuring that full DBS checks were obtained before staff go out visiting people.

This meant that the provider had not taken all possible measures to ensure people were cared for by suitable staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service used medicine administration records (MAR) to record medicines that had been given to people from monitored dosage systems (dosette box) and from individual packs or boxes. Dosette boxes are containers that hold all of an individual's medicines together in an easy to use blister pack.

Three of the four people we visited had incomplete information regarding their medicines to be administered by staff. One person's record was not fully completed with gaps in recording evident and the medicines listed did not match those in the dosette box. We asked staff to check with the person's GP who confirmed that medicines had recently been changed. However, staff had not updated the MAR to match. The manager confirmed they had followed this up the next day to ensure correct procedures were in place. Another person was prescribed an anti-coagulant medicine (variable doses) on particular days. Family members gave on some days and staff on others. The MAR stated 3mg only to be given on a particular day, but a separate list indicated 2mg was to be administered. We confirmed through the person's medicine booklet from the GP that the staff had, in fact, been administering the correct 2mg dose. The MAR was therefore incorrect and staff had signed this. There were gaps in the MAR where relatives had administered medicines but staff had not coded the record correctly to reflect this. There was no medicines risk assessment in place to account for this.

Other MAR's we reviewed did not always give the full details and timings of where and how to administer people medicines. For example, topical creams and transdermal patches. Topical medication refers to, for

example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin into the bloodstream. The provider told us they were reviewing all of this information and updating medicines risk assessments to ensure they captured full detail. This included making sure that body maps and patch application charts were in place where required.

Particular medicines require additional measures to be taken by staff when they administer them to people. For example, with one medicine the manufacturer recommends that people are either standing or sitting up when they take this medicine as prolonged administration when lying down can cause erosion within the oesophagus (gullet or food pipe). When we asked one family how their relative received this medicine, they told us that staff administered it as soon as they arrived when their family member was still in bed. They told us staff then waited the correct time before they administered the rest of their medicines or then supported the person with breakfast. There were no instructions for staff to follow manufacturers guidance which meant the person was placed at unnecessary risk.

One person we visited had medicines stored in a separate storage area adjacent to the back of their home. We observed that staff had left the back door to the property open while they were providing personal care. We brought this to the attention of the staff on duty at the time and they confirmed that they normally didn't leave the door open, it was only because it was a hot day. We brought this to the attention of the nominated individual who said he would address this issue.

We observed one staff member prepare medicines for two people at the same time by removing medicines from their dosette boxes and placing the medicines into small containers. They then took both the cups together to administer the medicines. This practice is particularly dangerous as staff run the risk of mixing the medicines up and people possibly receiving the wrong ones. We closely observed to make sure that both people received the correct medicine, which they did. We reported our concern to the nominated individual who said they would address this issue.

In a staff meeting in May 2017, the manager had recorded in the minutes, "Medication, there (they) are a mess at the moment, missed signatures and crossings out, medication being signed for that hasn't been in the dosette for a month."

Some of the risk assessments that we reviewed in people's care records had not always been completed fully. For example, one person's risk assessment in connection with moving and handling had a task which staff completed in connection with 'supporting the person away from the care workers body'. The risk section of the form had not been completed, even though this had been an identified hazard. On another person's risk assessment in connection with animals, it had not assessed the risk for staff who may be allergic to that particular animal. A falls risk assessment for one person had documented issues with the person's sight. However, there was no mention of this in the risk management plan produced to reduce any potential hazards and help minimise falls.

We also found some risk assessments which were in need of review. For example, one person's moving and handling and medicines risk assessment were last reviewed in November 2015.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The vast majority of people told us they felt safe and comfortable with the care staff who visited them in their homes. Comments included, "Safe yes without them I'd be a mess. I have a hoist in the bedroom and

an aid in the toilet, I always feel safe"; "Safe definitely"; "Safe yes, dead friendly and helpful."

Relatives thought their family members were safe when they received care from the staff. Comments included, "Safe yes they are very helpful if there's any problems they get in touch"; "Safe, yes from the first meeting"; "All lovely, fully trust them; all regulars"; "Very good with [person], no issues we trust these carers as we've been through quite a lot in the last 18 months" and "They [care staff] are professional, friendly and [person] is in safe hands."

Incidents of a safeguarding nature were monitored. A file had been set up to hold information about the local authority procedures and the provider's own policy. Incidents were logged on a specific form with outcomes documented. Information about relevant incidents was passed to the local authority safeguarding teams, although notifications had not been always sent to the Commission. The staff we spoke with were clear on what constituted a safeguarding concern and were able to explain the correct process they would follow to report any issues. Staff had also received appropriate training to support them with any safeguarding matters.

The provider had an 'on-call' service which operated outside of normal business opening hours. Logs were kept of incoming and outgoing calls during 'out of hours' to ensure that issues and concerns were reported appropriately. People and staff could use this facility if they needed support when the office was closed. One relative told us, "The managers are on call all the time, [provider and manager's names]."

There was a business continuity plan in place which documented what actions the organisation would take should some form or emergency occur, for example, severe weather, major transport disruption or flu pandemic. The provider had identified which elements of the service were critical, for example, to be able to continue providing care to those people with complex needs or time sensitive medicine regimes. This meant should an emergency situation occur, the provider would be able to implement their plan to ensure that people continued to receive care as soon as possible.

People and their relatives had mixed views on whether there was enough staff working at the service, timings of care calls and continuity of care staff. One person told us, "They can sometimes run a little late, but you cannot expect them to be here bang on the dot. All in all though they are very good." Another person told us, "There is enough staff and I know them all." A third person told us, "Carers get a rota and tell me who's coming when. Pretty much on time." A fourth person told us, "Yes, there is enough staff…well, I have never had a problem, put it that way." However, one person was a little concerned about the number of staff changes they had recently had. We contacted them a second time and also spoke with their social worker. It was confirmed that some longer term carer staff had recently left and it had unsettled them. This was in the process of being resolved. People told us that they didn't feel rushed and that staff sometimes had time for a cup of tea and a chat before they had to leave.

Relatives comments included, "When possible they [provider's office staff] try and maintain the same carers going to see my [relative] so they get to know [person] which is excellent"; "We get a printed rota once a week emailed to us"; "Most of the staff are regular and they are flexible and can meet extra needs. I've got the manager's mobile so can always contact them"; "One of the carers didn't turn up because of an emergency, I phoned them and they got another carer to us in 15 minutes."

However, one relative told us, "There's a big turnover of staff, not enough staff, very stretched." Another relative told us, "We had a couple of issues recently with staff not turning up. They had generally been good up until then."

Staff told us they felt there was not enough people employed by the service to manage it effectively. They also said sometimes they did not always get enough time to 'get to know' people fully before being asked to provide care. On the providers website it stated they would always send the same carers. However, the provider had recognised the current situation they found themselves in and was in the process of a recruitment drive. They had recently employed a human resources person who would support this task.

There had been a very small number of missed calls reported. The manager told us whenever a carer contacted them to report their unavailability, they would either get another carer or a trained member of staff from the office to attend, including themselves if necessary. They said they always investigated any missed calls and learnt from how this may have happened to try and ensure it did not happen again, including discussion at morning meetings at the service. We were made aware of one staff member who was unable to make a care call. We contacted the relative and they confirmed that care staff had arrived and were "just slightly late, but not a problem."

The provider was planning to introduce a new IT and linked telephone system which would flag up any missed calls. This meant any potential issues with carers arriving early or late would be identified quicker and actions could be taken sooner.

Requires Improvement

Is the service effective?

Our findings

Not all staff had received regular supervision and annual appraisals from the records that we checked. For example, one staff member had their last supervision session recorded as 16 August 2016, while another had theirs recorded as 23 November 2016. Another newer staff member had no support sessions or checks recorded at all on their personnel file. Not all longer serving staff had received an appraisal.

Three staff we spoke with were feeling disgruntled and unsupported, whilst others felt supported. One told us they had not received suitable support and was thinking of leaving because of it. All the staff we spoke with, however, enjoyed providing care to the people they supported. One staff member said, "No matter how I feel, it has no impact on the person I am working with."

We spoke with the provider about our findings and they confirmed that this was an issue and they were working to address it.

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

Most people and relatives felt confident that care workers were effective and well trained. Comments included, "Very efficient. I have some regular staff"; "I have one regular staff and when they are new they shadow"; "All the staff are trained now and know what they are doing"; "[Person] has regular carers. I insisted because of how [person] was. They are experienced"; "The girls [care staff] have learned very quickly about [person's] needs. Six look after [person] and they know them all. New ones [care staff] shadow"; "Over the last three years the care they have received has been excellent 99% of the time. As in any situation in life problems may occur but they are rare. When I have raised concerns they have been addressed" and "They are very conscientious. We have a good relationship and a good rapport. We've been with them three years, from when the company started. They are very professional."

However, we received comments from one person and another person's relative who thought newer staff were not always as effective as the more permanent staff.

Staff completed an induction programme on joining the organisation. Staff also shadowed more experienced staff before they were allowed to support people themselves. The provider had incorporated the Care Certificate as part of their induction programme. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards. There had been a new member of staff recently recruited whose focus was on training and development. We observed training taking place during the inspection and one staff member briefly told us when asked, "It's good."

Staff told us and personnel records confirmed that staff training was completed in a range of subjects which the provider deemed mandatory. These included, medicines, safeguarding and moving and handling. One person said, "I don't know much about their training, but they appear well trained and experienced." One

relative told us, "The girls [care staff] are very confident and trained very well." One staff member told us they had completed CPR training (cardiopulmonary resuscitation). They explained correctly the action they would take if someone required CPR. Care staff were trained in safe handling of medicines.

Checks on staff competency were completed in a number of ways, including for example, through questions via the interview process when staff applied for care work and competency checks completed by district nurses where staff supported people with more specialist care. For example, those who had catheters fitted. A catheter is a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid.

The staff used an instant messaging application which was secure to the provider, called WhatsApp. This meant staff could use mobile phones to send pictures of people participating in various activities or pictures and narrative people wanted to pass on to others. This was all done with the consent of people and we confirmed this. We were shown how the system worked by one staff member who said, "It's great, people love to get involved and post pictures of themselves out and about. It's nice for the office staff to see too as they don't always see the good things going on in the community."

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

Copies of Lasting Power of Attorney were not always in place, although the provider had requested copies from families or relevant people and these were in the process of being gathered. There was no evidence to suggest any impact on any decisions which had been made. Records of people's assessed capacity was not always documented unless via information from the local authority and as some clients were privately funded, this information was not detailed in all records. The provider had implemented new paperwork to update and review this information which included a record of any best interest decisions which may be required.

We recommend the provider reviews records to ensure they are working within the principles of the MCA.

One relative told us their family member's eating regime had improved since care staff had started to support them. They said, "[Person] is eating better than at Christmas when it first started." People told us care staff ensured they had enough to eat and drink, including when staff finished their shift by leaving snacks and refreshments if required. People were assisted to eat their meals if this was agreed in their care plan and those people who had special dietary requirements were also supported appropriately. We saw one person had been referred to the Speech and Language Therapy Team (SaLT) and documents which confirmed staff were following their recommendations. SaLT is a team of healthcare specialists who support people, for example, who are at risk of choking. For some people entries in their daily communication notes indicated care staff had visited the local shops to purchase food items and financial transactions were recorded appropriately.

The service supported people to maintain their health and wellbeing. People's care records showed that care staff had reported concerns to the office staff regarding people's general healthcare needs. In addition, we saw records which confirmed office staff had contacted GP's and other healthcare professionals on a person's request or behalf. One person told us, "The girls [care staff] had to call an ambulance for me once… so glad they were here and got me sorted out."

Good

Is the service caring?

Our findings

People told us their care workers were 'lovely' and very caring and some were like extended family. Comments included, "Yes friendly and helpful, we have a good banter. They are respectful and caring. [Name] the manager, I saw her a couple of weeks ago she is really friendly"; "The lasses are perfect. Would not change them and don't know what I would do without them. They are very caring and do so much for me." One person told us, "They [care staff] are like part of the family now."

Relatives felt that the provider and their staff were caring. Comments included, "What a difference this has made to us as a family. Well, firstly we can sleep at night knowing that [person] is in very safe and caring hands. From the top down this team has been amazing"; "Kind, caring and respectful. They do a very intense and often difficult job. Without the care [person] has received in their own home I do not think their life would have been prolonged"; "[Person] has two to three really good carers. They talk [person] through everything, 'would you like your nails doing' 'have some make up on?' or 'wash your hair today?' All good"; "They are professional and friendly and I've met most of them they're all wonderful"; "They are caring and very efficient, pretty good with privacy and dignity with [person], very nice have a banter"; "I've got a very good relationship with the carers"; "They are very helpful, the care is person centred. They [person] get on fine"; [Person] enjoys the company of the girls [care staff] who have learned quickly about their needs. They are always kind and polite and have a little chat"; "I'm very happy with the quality of the care"; "They are all lovely…The girls are kind caring and compassionate"; "They are caring, kind and compassionate. They have a good relationship with [person] and myself" and "They are friendly and all wonderful."

All of the people and the relatives we spoke with told us they had involvement with the planning of their care. Comments included, "Yes, I have been involved. They are always asking me if everything is okay. I had to give them a load of information at the start"; "I had an assessment and I made the rules in the care plan. I've got a list on the fridge what to do. I'm confident with them and trust them"; "I had an assessment and I feel quite involved"; "[Person] had a two and a half hour assessment with the manager. I was fully involved"; "We had an assessment and after the first week the manager's came to my house [provider's name and manager's name]. We also have a meeting every six weeks to discuss things" and "[Person] had a full assessment and a care plan and I am fully involved" and "[Person] is continually assessed, it's very person centred care, we're fully involved with the care."

People and their relatives told us that they were given opportunities to provide feedback about the service provided, either through surveys, visits to their home or phone calls. One person told us, "[Provider's name] has been here many times, I can let them know my thoughts then." One relative told us, "I know I can speak to [provider's name] and raise any issues. Therefore I feel that we are listened to." Another relative confirmed, "We have had questionnaires."

Relatives told us they had a good relationship with both the provider and the staff they employed. Relative's comments included, "From the first meeting straight up, they [provider] email if it's urgent and so far everything's great. I can talk openly to them and not feel awkward. The carers came to see [family] and now all carer's are regulars. [Person] enjoys their [care staff] company";

One person told us care staff respected their dignity and them as a person. They said, "They [care staff] are very good with my privacy and dignity when I'm having a shower or a wash they keep me covered and when I'm going to the toilet. They always ask permission. If I'm worried about anything I can talk to [name] the manager." Another person said, "They [care staff] always shut the door and the curtains are closed. I am comfortable with the way they help me."

Relatives confirmed that their families dignity and respect were maintained and said, "They respect [person's] privacy and dignity they keep [person] covered (while performing care tasks)"; "They [care staff] always ask permission to do things and talk through everything with [person]; They are good with [person's] privacy and dignity"; "The girls [care staff] are good with [person's] privacy and dignity during their bed baths they keep [person] covered as they are bed bound"

We observed interaction between care staff and the people they supported during our visits to people's homes. The interaction was caring and friendly and the care staff displayed professionalism throughout the visit. We saw them offering reassurance and encouragement while they supported people with a variety of tasks.

The service was supporting people who were currently receiving end of life care. The people we spoke with who were receiving palliative care spoke highly of the care staff. We saw that where applicable, people's records contained information about advanced decisions and preferences around emergency treatment and resuscitation. People had DNACPR forms in place and staff knew how to locate them and what they were meant to do if an incident occurred. A DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly and is signed off by a suitably qualified healthcare professional.

We were told that some people had religious needs, but these were adequately provided for within people's own family. We saw no evidence to suggest that anyone that used the service was discriminated against and no person or relative we spoke with thought so.

Requires Improvement

Is the service responsive?

Our findings

Recently reviewed care records were person-centred and included detailed information about people's health and medical conditions. The records contained assessment documents from the local authority (if relevant) and showed involvement from a range of healthcare professionals to ensure that the correct care was in place if that additional level of input was required. However, not everyone's care record we examined was up to date or had been reviewed in line with the provider's policy, which included six monthly reviews. We found that some records contained information which was out of date or incorrect. For example, one record had the name of a person's wife recorded when they had passed away last year. Another care plan was implemented in April 2015 and reviewed in February 2016 but not since. Another care plan indicated the person was a diabetic. Staff told us that a GP had confirmed the person was not diabetic. This person was eating a normal diet, although other measures were in place because of their risk of choking.

People we spoke with confirmed that although their paperwork had not been updated, their care needs were being met by the care staff who visited them. One person we visited was able to confirm that care staff met their needs, although we observed their care plan had not been reviewed since 2016. They told us, "I ask the staff for things I need every day. They do everything I want and see to everything for me."

We checked the moving and handling risk assessment for one person which indicated checks on the hoist had not been completed since 2015. However, we examined the actual equipment and saw it had been recently inspected and checked. Staff told us that they monitored equipment, although they did not complete any checks themselves. One staff member told us, "We had someone out to check the bed not that long ago."

The nominated individual was aware that records needed to be reviewed and was currently ensuring that the management team were working their way through them. However, at the time of the inspection records were not always accurate or up to date.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that initial assessments were carried out prior to people commencing with the service. There was also a 'needs assessment worksheet' on the provider's website which enabled 'prospective customers' to start thinking about the type of support they or their family member may require. For example, it asked what level of help people might require with getting out of bed or bathing. This enabled people and their families to plan more effectively when care was possibly required.

People and relatives thought the care provided was person centred and responsive to their changing needs. One person told us, "They [care staff] have been wonderful since my wife passed away." Another person said, "Sorry, I get emotional…they [care staff] and [provider's name] have been very good. They have changed things around to make life as good as it can be." Relatives comments included, "The girls are conscientious and the care is person centred" and "Have been remarkably responsive to sudden changes in

circumstances"

One relative told us that staff had been very proactive to support their family member and said, "Anything suggested they take on board." Another relative told us, "When [person] was dying they rearranged everything at the drop of a hat."

People who had participation in activities as part of their care plan were supported by staff to meet their needs. Staff confirmed that people were taken to places they wanted to go. One person confirmed they enjoyed going to the theatre and said that staff had supported them to visit with other members of their family. Their relative confirmed this. We saw on a private instant messaging service the provider used that staff had posted pictures of people (with their permission) participating in a range of activities, from going to the hairdresser, shopping and craft events.

The service had received one formal complaint which had been dealt with appropriately. The provider had a complaints policy to support people and their relatives who felt they needed to use this process.

Some people told us they had never had cause to complain whilst others told us that the service had responded quickly to issues so they didn't escalate to formal complaints. One relative told us, "They can phone me any time and I can phone the manager any time with any concerns. They are very good with [person] I have no concerns".

Requires Improvement

Is the service well-led?

Our findings

We saw that the service used a range of quality monitoring tools. Audits were in place to monitor records such as, medicine administration records and daily communication sheets. Daily communication sheets are documents used in people's homes for staff to record the support provided to people on a daily basis.

However, audits completed had not always identified the issues we found, during our inspection. For example, the issues with medicines, recruitment and care records. We noted audits of medicine records were not always fully completed with the action the provider was going to take. For example the auditor had marked that entries had not all been signed to confirm medicines had been administered. No action was recorded, which meant we could not be assured what measures had been put in place to stop this occurring again.

The provider had no robust system in place to check that documentation in staff files was up to date, including for example, car insurance. On review, we found that staff had brought in copies of driving licences and car insurance documentation. We found, however, that not all the documents were up to date. For example, insurance for one staff member was out of date and another was not clear if they were insured for business cover.

The provider was aware that supervisions and appraisal of staff had not always been completed and were now trying to address this with the new manager taking the lead. However, this had not been found through quality assurance checks completed.

The provider organisation is a franchise of 'Right at Home' which have branches across the country and offer support to providers in different areas. A 'Compliance and Quality Audit' had taken place in August 2016 by 'Right at Home' staff to support the provider. We noted that a number of the issues we had found had been highlighted to the provider, including for example, issues with mental capacity, best interest decisions and review of care plans.

The nominated individual told us some actions should have been completed after this audit and they thought they had been. The provider acknowledged that the findings of our inspection had been a 'steep learning curve'. They recognised more robust quality assurance checks needed to be in place so that they, as the provider, could monitor the service better.

Since the inspection, the provider told us they had taken on board comments and feedback given and confirmed they had 'tightened up' audits and their own checks. However, at the time of the inspection, effective systems were not fully in place to ensure compliance with the regulations.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection there no registered manager in post. The last registered manager had left the

organisation in November 2016. A new manager had been appointed and they were in the process of applying to become the registered manager. There had been an unnecessary delay in their application and we are dealing with this outside of the inspection process.

The provider was aware of their responsibilities regarding notifications, however, we found they had not submitted all necessary notifications to the Commission. Notifications are incidents, for example, safeguarding concerns or deaths, which the provider is legally obliged to send the Commission. Two notifications of allegations of abuse had not been sent to the Commission though had been reported to the local authority safeguarding team. Although they had been dealt with appropriately, this is not in line with the provider's registration and legal requirements. We have written to the provider and will consider their response and then make a decision on our next course of action.

People told us that the management team and office staff were friendly and available. One person said, "The managers are approachable and the office staff." Another said, "[Manager's name] the manager, she's lovely." One healthcare professional was highly complimentary of the deputy manager and said, "She is very good and understanding."

A relative told us, "[Manager's name] and [team leaders name] are diamonds." Another relative commented, "In the past we have had another care company which unfortunately were terrible so I have been able to make comparisons. It is every human beings right to be cared for with compassion, enabling them as much as possible to maintain a sense of self and dignity and that is what I wish for my [relative]. With Right at Home's help [person] is receiving the care [person] needs and in the place [person] wishes to stay."

However, one relative commented, "[Nominated individual's name] is not as good as they used to be. I think it is because they have taken on too much and have not got the time now."

Spot checks were being carried out. People confirmed that senior staff had visited their home to spot check the staff who were supporting them. One person told us, "Cannot remember when it happened, but the manager came and made sure everything was okay."

Communication was an area which a number of staff told us had been poor but was continuing to be improved with the new manager in place. One staff member told us, "It (communication) was really bad before, but since people have left and new management have taken over, things are gradually improving."

Staff meetings took place and we saw minutes which confirmed that staff had an opportunity to raise any issues or concerns with the manager and it was recorded at times staff had. The meetings had an agenda made up of a range of topics, including for example, asking staff if they had any concerns with the people they cared for, medication issues, dress code and training. An action plan that had been completed by the provider confirmed that meetings were to be held monthly for staff in the future and this would support the need for continuing to improve communications with the staff team.

All surveys were dealt with via an independent research company who gathered the responses and reported back the results to the provider. We reviewed the surveys for the last two years and noted a very slight decline in positive responses from the year 2015 to 2016. For example in 2016, 88% of the respondents had said they would recommend the provider while in 2015 it was 100%. We saw through the inspection that the provider was taking action in the areas they considered needed improvement, for example, recruitment, record keeping and quality assurance systems.

On the providers website they supported people and their families by providing information on a range of

care related issues. This included, how to find about how much care allowance people and families may be entitled to, falls prevention advice and signs to watch for in determining if additional help may be required.

The provider had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is a Department of Health initiative. The provider was also registered with Social Care Institute for Excellence (SCIE). SCIE aims to improve the lives of people who use care services by sharing knowledge about what works.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken proper steps to provide care and treatment in a safe way for service users. They had not ensured the proper and safe management of medicines. Risk assessments were not always up to date. 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust quality assurance processes in place to effectively monitor the service. People's records were not accurately maintained or reviewed. 17 (1)(2)(a)(b)(c)(f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not always followed safe recruitment practices. 19 (1)(a)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not always provided staff with

suitable supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

18 (1)(2)(a)