Mears Care Limited

Mears Care Brighton

Inspection report

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Date of inspection visit:
14 November 2016

Date of publication:
07 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 November 2016 and was announced. This was the first inspection since the service was re-registered following a new provider taking over the service and a change in name. This service was formerly Brighton Community Care Services DCA.

Mears Care (Brighton) is a domiciliary care agency and provides personal care and support for people living in their own home in the Brighton and Hove area. Care was provided to adults but predominantly older people, including people with a physical disability or learning disability, people with a sensory loss, for example hearing or sight loss and people with mental health problems or living with dementia. At the time of our inspection around 130 people were receiving a service.

The service had a registered manager, who was present for the inspection. 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.

This inspection was carried out due to the number of concerns the CQC had received about the service provided in relation to missed calls and the time care calls were being provided. Staff told us there had been a significant period of change in the management arrangements and personnel working in the office leading to staff vacancies of senior staff and care staff. The registered manager had recently been registered to also be the registered manager for another of the provider's services and split their time between both these services offices. The registered manager was on site two days a week. They were contactable when not on site. However, feedback from people and care staff demonstrated there was a lack of clarity of the management arrangements for the service. The current management arrangements did fully support the operation of the service. Procedures such as care and support plan reviews, quality assurance checks, spot checks of care staff at work, staff supervision, team meetings and staff appraisal, investigations into concerns and complaints raised and quality assurance audits had fallen behind and not been fully completed to meet the provider's timescales. People told us there had been a period of a lack of consistency of times the care calls were provided. The registered manager told us about the difficulties in recruitment of new care staff had led to the use of agency staff to help cover care calls. This had led to a lack of consistency in the care staff covering people's care calls. Because of this people told us they did not always feel care staff understood their care and support needs. One member of staff told us, "If you have regular carers, it runs smoothly, but it's not happening as much as it should be. It's important for people with dementia to have continuity. They just want a face that they know, but that's not happening at the moment." Care staff told us there was a lack of sufficient travel times between care calls to ensure people's care was delivered at the time agreed. Where people had raised concerns the feedback was varied when asked if they felt their concerns had been resolved. We have asked the provider to make improvements in all these areas.

Consent was sought from people with regard to the care that was delivered. All staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA)

and associated legislation. Where people were unable to make decisions for themselves, staff had considered the person's capacity under the Mental Capacity Act 2005 (MCA), and had taken appropriate action to arrange meetings to make a decision within their best interests. Staff told us they always asked for people's consent before they provided any care and support. One member of staff told us, "Absolutely it's all about choice. We're not there to tell people what to do. I make adjustments every day to give them what they want."

Where required, care staff supported people to eat and drink and maintain a healthy diet. People were supported with their healthcare needs. One member of staff told us, If somebody is not well I will call the office or call an ambulance. I would record it and ask the next carer to check on the person as well." Medicines were managed safely and people received the support they required from staff.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back 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.

People did not routinely have their individual needs met in a timely manner. Staff rotas contained no travel time and staff were regularly late for calls.

People were cared for by staff who had been recruited through safe procedures. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

People had individual assessments of potential risks to their health and welfare. Procedures were in place to ensure the safe administration of medicines. However, the medicines audit system in place did not ensure any errors in recording were followed up in a timely way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a comprehensive induction and training plan in place. However, care staff had not received regular supervision and appraisal.

Care staff had an understanding around obtaining consent from people, and had attended training on the Mental Capacity Act 2005 (MCA).

People were supported to eat and drink enough and they were enabled to access health services when necessary.

Is the service caring?

Good

The service was caring.

Care staff involved and treated people with compassion, kindness, and respect. People told us care staff provided care that ensured their privacy and dignity was respected.

Care staff were able to explain the importance of confidentiality, so that people's privacy was protected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had been assessed and their care and support needs identified. Care and support plans were in place. However, regular reviews had not been maintained.

People told us that they knew how to make a complaint if they were unhappy with the service. However, not everyone felt their concerns had been fully addressed.

Is the service well-led?

Requires Improvement

The service was not constantly well-led.

There was a registered manager for the service. However, feedback from people and staff demonstrated a lack of clarity as to the management arrangements for the service. The registered manager was split between two services and so unable to devote sufficient time to the service to address issues highlighted.

Systems were in place to audit and quality assure the care provided. However, these had not been maintained or fully embedded and up and running.

The leadership and management promoted a caring and inclusive culture.

Mears Care Brighton

Detailed findings

Background to this inspection

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

This inspection took place on 14 November 2016 and was announced. We told the provider two days before our inspection that we would be coming. This was because we wanted to make sure that the registered manager and other appropriate staff were available to speak with us on the day of our inspection. Two inspectors undertook the inspection, with an expert-by-experience, who had experience of older people's care services. 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 expert by experience helped us with the telephone calls to get feedback from people who used the service and relatives.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and any complaints we have received. This enabled us to ensure we were addressing potential areas of concern. We telephoned the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. We also received feedback from two social care professionals about their experiences of the service provided. We spoke with 17 people and one relative who used the service.

During the inspection we went to the services office and spoke with the registered manager, the regional recruitment officer, a visiting officer, two care co-ordinators, a senior care worker, and five care staff. We spent time reviewing the records of the service, including policies and procedures, ten people's care and support plans, the personnel records for three care staff, complaints and compliments recording, accident/incident and safeguarding recording, and staff rotas. We also looked at the provider's quality assurance audits.

This was the first inspection since a new provider took over the service.

Requires Improvement

Is the service safe?

Our findings

Generally people told us they felt safe with the care provided by staff in the service. "Yes I do with the carers." Another person told us, "Yes with the regular carers." A third person said, "Definitely." People who had help with their medicines told us this had worked well. One person told us, "Yes, they do it properly." However, risk assessments had not all been reviewed. The current system of scheduling care calls placed people at risk of not always get the assistance they needed when they needed it. One person told us, "They (Care staff) are often late but they usually turn up eventually. Five months ago I had missed calls for three nights, I slept in the chair. Since then it has improved. Tonight I have been told that I have to go to bed at 6.30 pm." The medicines audit system in place did not ensure any errors in recording were followed up in a timely way. These are areas of practice which are need of improvement.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them, and protect people from harm. Each person's care and support plan had an assessment of the environmental risks and any risks due to the health and support needs of the person, and these had been discussed with them. The assessments detailed what the activity was and the associated risk, and guidance for staff to take to minimise the risk. For example, where people needed help to move, there was clear guidance for staff to ensure this was done safely. Care staff were able to confirm with us they had received training, had detailed guidance in place, and of procedures they were to follow. They told us that the care and support plans and risk assessments reflected the care that was being provided. However, these had not all been reviewed to meet the providers requirements. We discussed this with the registered manager who with senior staff told us they were in the process of reviewing the risk assessments. This was confirmed in the sample of records we looked at. This is an area of practice which is in need of improvement.

Staff were not always deployed effectively and sufficient time was not consistently allowed for travel between visits. This resulted in care staff often being late for visits. We spoke with the office staff who told us they tried to allow time between each call. However, feedback from and people and care staff was adequate travel time had not been routinely included between scheduled care visits. Travel time should be reflective of distance and times of the day where delays could be encountered, such as during the rush hour and the school run. One person told us, "I once had an early meal at 3.45pm, it should be 6.0 pm. I expect a call at 8.0 am sometimes it's 10.0 am or after, they don't ring to let me know. When I have rung the office they told me they hadn't got anyone to come, so I lived on biscuits and crisps. It has improved, it is better than it was." We asked staff what they thought of the call scheduling and the amount of travel time they received between each call. One member of staff told us, "We don't get enough travel time, so you are set up to fail before you start. Sometimes you get none at all and other times you might get five minutes. They just say get there when you can." Another member of staff told us," All the clients know we don't get travel time. We are always late, but we try to meet the times as much as possible. I change my rota when I get it. I ring the client's and say I will be 10 minutes late every day this week, otherwise they panic." A third member of staff said, "I don't get enough travel time. Sometimes I'll have eight calls to do and five of them won't have any travel time in between. I would be an hour late by the sixth call. I still have calls scheduled to finish at 5.30 pm and the next one to start at 5.30 pm. I fed this back and they took some calls off me."

Where people relied on assistance from care staff for example, to prepare a meal or take their medicines, the current system of scheduling care calls placed them at risk of not always get the assistance they needed when they needed it. This increased the risks of people not having their nutritional needs met or becoming ill due to not having their medicine. Additionally it had not always been ensured that people received care from people with the necessary skills, or where people required two members of staff to provide their care. For example, one person told us," I have a ceiling hoist I have to tell them how to do it. I sent one away. I didn't feel he was capable of using the ceiling hoist or the stair lift." Another person told us, "Ones that do come are very good very helpful, I need two carers and quite often I only get one person. We manage the best way we can, I really need two people when I use the commode." This is an area of practice which is in need of improvement.

People did not receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care calls placed people at risk of receiving late calls, or having their calls missed altogether. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicines policies and procedures were in place for staff to follow and there were systems to manage medicine safely. Care staff told us they had received medication training to ensure they were following the required policy and procedures. An audit system was in place to check medicines administration and recording had been completed. We looked at a sample of the recording of medicines and saw in some cases not all medicines had been recorded when given on the medication administration records (MAR sheets) used to record support with medicines administration. The audit system in place did not ensure errors in recorded were followed up in a timely way. We discussed this with the registered manager, who told us they were aware of this and had already made changes to address this, to ensure any errors in recording were found this had then been discussed with the care staff who had not been recording accurately. This is an area of practice which requires improvement. Not everyone we spoke with had support with their medicines. For one person who was supported with their medicines, they told us they had been happy with the care provided, "Yes, make sure you take, it is perfectly well." Another person told us, "They pick up my dosette box. One thing they do properly, they get the pack they put them in the glass. They watch me take them and swallow it down with juice." A third person said, "They do the creaming, got no problem with this, they use gloves and aprons."

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen at the service in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example, where abuse was suspected. Care staff all demonstrated knowledge of the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Procedures were in place for staff to respond to emergencies. Care staff had guidance to follow in their handbooks and demonstrated they were aware of the procedures to follow. For example, care staff were able to describe the procedures they should follow if they could not gain access to a pre-arranged care call. The care staff told us they would report this to the office straight away and enable senior staff to quickly locate the person and ensure they were safe. There was an on call service available, so care staff had access to information and guidance at all times when they were working. Care staff were aware of how to access this should they need to.

The registered manager and regional recruitment officer told us of the difficulties which had been experienced in trying to recruit new care staff, and of initiatives which had been introduced to try to address this. At the time of the inspection there were a number of staff vacancies which were being covered by agency staff. The registered manager told us they were actively trying to recruit new staff and were only taking on new work if they had the care staff to cover the care calls. We asked staff if they felt that the service had enough staff to meet the needs of people. One member of staff told us, "I think we have enough staff." Another member of staff told us, There has been too much changing of staff, it doesn't run well. If you have regular carers, it runs smoothly, but it's not happening as much as it should be. It's important for people with dementia to have continuity. They just want a face that they know, but that's not happening at the moment." A third member of staff said, "There was a time when calls weren't being met. This has improved now and we are getting to all the calls, so I think we have an adequate number of staff."

Comprehensive recruitment practices were followed for the employment of new care staff. The registered manager had the support of the provider's human resources department when recruiting staff. They told us that all new staff had been through a robust recruitment procedure to meet the requirements of the provider's policies and procedures. We looked at the recruitment records for two care staff recruited, and we checked these held the required documentation. New care staff had been through a recruitment process, written references had been sought, and criminal records check had been carried out by the provider to ensure that potential new care staff had no record of offences that could affect their suitability to protect adults.

Requires Improvement

Is the service effective?

Our findings

People's feedback was varied when asked if staff understood their care needs, and provided a good level of care. One person told us, "Most of time they understand needs and have the right training." Another person told us, "When they get used to you, but not when they are new. Regular carers normally are perfectly okay." A third person said," It's a mixture some do and some don't. Some don't seem to know what they are doing." One relative told us, "They are competent." Staff spoke well of the induction and training provided. One member of staff told us," My induction was helpful and I did about three days shadowing." However, they had not all received regular supervision and appraisal and did not all feel well supported. One member of staff told us, "I don't feel supported." This is an area of practice which is need of improvement.

Feedback from care staff was that they had not received regular supervision and appraisal. Spot checks to review the quality of care provided had not been maintained. One member of staff told us, "I've sat down once in a year for supervisions and I've never had an appraisal. I had a spot check once." Another member of staff told us," I've had supervisions and staff meetings, but not lately. The last staff meeting we had was about a year ago. That's when I raised concerns, nothing is done though, so you think what's the point of saying anything." A third member of staff told us, "Who is my supervisor, who is my manager. I don't know?" I don't feel supported." We discussed this with the registered manager who acknowledged that staff supervision and appraisal and staff meetings had not been maintained. However, this had been identified and work was already in progress to ensure care staff had an appraisal and then a supervision plan. This is an area of practice which is need of improvement.

People were at risk as care was provided by care staff who not receive the supervision and appraisal they needed to support them in their role, and to help ensure the quality of the care provided. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were supported by care staff who had the knowledge and skills to carry out their roles. The registered manager told us all care staff completed organisation's five day induction. This was confirmed in the sample of recording we looked at. The induction had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of 'shadowing' a more experienced staff member, before new care staff started to undertake care calls on their own. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. Feedback from care staff was that the induction had been good and informative. One member of staff told us, "They explained the job fully to me before I started and the induction was good. It went on for five days and covered different subject every day. It was useful." Another member of staff told us, I had a one week induction with tests and quizzes." A third member of staff told us, "The induction is really good. The trainer was very good and we could go to her for advice and extra training."

Staff received training to ensure they had the knowledge and skills to meet the care needs of people. Care

staff received training that was specific to the needs of people, which included moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, catheter care, dementia care and infection control. Where people had specific care needs, for example moving and handling, using a hoist or where people were living with dementia training had been provided. Care staff told us they were up-to-date with their training, they had received regular training updates and there was good access to training. One member of staff told us, "Our training is the best. It's all done in the office and we support the care staff to learn." Staff were being supported to complete a professional qualification and training records we looked at confirmed this.

Staff demonstrated an understanding of and there were clear policies around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Staff told us they had this training. They all had a good understanding of consent, and where people lacked the capacity to make decisions about their care and welfare. One member of staff told us, "We get good training. I've done safeguarding and MCA, I know about consent."

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager had a good working knowledge of the Deprivation of Liberty Safeguards (DoLS). Although DoLS does not apply in a domiciliary care or supported living setting, the principles apply, but any authorisations for restrictions would go through the Court of Protection.

Where required, care staff supported people to eat and drink and maintain a healthy diet. People were supported at mealtimes to access food and drink of their choice. One care and support plan detailed, 'Wishes to have support to maintain a healthy diet for diabetes.' Another detailed, 'Likes a straw with her drinks.' One member of staff told us, "I cook and it's fine, I've had no complaints. I always ask what people want me to do and as long as it's reasonable, that's fine. It's their choice." Another member of staff told us when asked people chose what they wanted to eat, You bring out several choices." Care plans provided information about people's food and nutrition needs. If people had been identified as losing weight, care staff told us there were food and fluid charts they could use, and these were completed to monitor people's intake. One member of staff told us, "The care plan says about any special diets. One lady is lactose intolerant and we make sure she has special milk." One person told us, "They give me in 15 minutes two fried eggs. I am happy with service from the carers. They often do washing up." Another person told us, "The other day, the carer didn't ask me what I wanted and made something absolutely inedible it was hard as nails. Most of them do what I want and cook it okay." Care staff had received training in food safety and safe food handling practices. However, we received some negative comments about standard the food cooked. One person told us, "Especially on tea times calls, quite often they send staff that can't even cook. Tea time potatoes not cooked properly, beef burgers are pink in the middle. I have had to change my diet so they can cook the meals. (e.g. from steak and vegetables). I have a lot of jackets potatoes frozen ones now." This feedback was passed to the registered manager during the inspection.

People had been supported to maintain good health and have ongoing healthcare support. We were told by people that most of their health care appointments and health care needs were co-ordinated by themselves

or their relatives. However, care staff were available to support people to access healthcare appointments if needed. One person told us, "The carer arranged for the doctor to come because I had a bad cold she was supportive." Another person told us, "The carers call the doctor for me." A third person told us, "They phone the doctor and order my tablets." One member of staff told us, "I would recognise if someone wasn't well. I've called an ambulance before, I've seen everything."

Good

Is the service caring?

Our findings

People told us people were treated with kindness and compassion in their day-to-day care. They were happy and liked the staff. One person told us, "Most of them (carers) are great" When asked how staff ensure people's privacy and dignity one member of staff told us, "I've not had a bad experience with any of the clients, they are lovely and they are happy to see us. I always ask what would you like to wear and give choices. Do they want tea or coffee and what do you want for breakfast. One lady I see has a very specific way of doing things. I respect their choice." Another member of staff told us, "Closing the windows, covering people up and asking and explaining what you are about to do. Offering choices and seeing what they can do themselves, and not assuming they can't do it." A third member of staff said," I like it here. I get positive responses from the people I visit."

Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understanding of the importance of respecting people's privacy and dignity. People told us they felt the care staff treated them with dignity and respect. Care staff had received training on privacy and dignity and had a good understanding of how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they treated them with respect. One member of staff told us, "You've got to offer choice, some people can't make decisions, but you still have to try. I always close doors when giving personal care." Another member of staff told us, "I minimise the state of undress to assist people's dignity." A third member of staff said, "You've got to get people to help if you can to encourage independence. Absolutely it's all about choice. We're not there to tell people what to do. I make adjustments every day to give them what they want. I minimise the state of undress to assist people's dignity. I would always encourage people to do things for themselves, I don't want them to lose their skills. As much as they are able, they help themselves if they can do it."

Care staff told us how they knew the individual needs of the person they were supporting. They told us they looked at people's care and support plans and these contained information about people's care and support needs, including their personal life histories.

Care records were stored securely at the service's office. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all care staff and was also included in the staff handbook. People received information around confidentiality as well. Care staff were aware of the importance of maintaining confidentiality and could give examples of how they did this.
For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the information guide given to people. The registered manager was aware of who they could contact if people needed this support.

Requires Improvement

Is the service responsive?

Our findings

Care and support plans were a mix of systems and paperwork from the previous provider to the current provider. These had not all been regularly reviewed to ensure people's care and support needs were being met. A relative told us, "They have reviewed the care plan in the past but not this year. We made an appointment on 27th April 2016 They did not come, not a telephone call to apologise or make another appointment I didn't ring them as I have had other problems at the time with the office paying a bill with the crossover of agencies. It took until September to sort this out. I thought what is the point in ringing them about the appointment." Where people had raised and concern or complaints the feedback was varied as to if people were satisfied with the response they had received. These are areas of practice which are in need improvement.

Each person had their individual care plan. A care plan is something that describes in an accessible way the services and support being provided to the person. They should be put together and agreed with the person involved through the process of care planning and review. Formal reviews of people's care ensure that any alterations in people's care and support needs can be identified and changes implemented if required. Care and support plans were detailed with information as to how the person was to be supported. Not all the care and support plans we looked at had been reviewed. Feedback from people was that not all had had a review of their care and support plan. One person told us when asked if they had had a review of their care and support, "Yes, five or six months ago." Another person told us, "The care plan is reviewed every few months by the team leader who comes to a quality check. She asks me what my needs are. It is okay most of time." A third person said, "I have a care plan they (carers) don't look at and it has not been reviewed. My health has deteriorated my needs of change I feel I could do with more care. They never look at the care plan just ask what needs doing, I have memory issues and can't remember everything that needs doing. My Dad has typed out a sheet for the carers he wrote it all down so the staff at lunch time would know what needs doing without needing to ask me." Feedback from care staff told us that people's care and support plans were able to give them the information they needed. One member of staff told us," The care plans are useful and contain good information." Another member of staff told us," The care plans are up to date and I read them. I get updates on text or a phone call. I phone the office with any concerns, they are usually willing to help." Care and support plans were a mix of systems and paperwork from the previous provider to the current provider. We discussed this with the registered manager and senior staff who told us this had been highlighted and staff were already working to address this and ensure all had been reviewed. This is an area which is need of improvement.

People were at risk of not receiving the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. This was because care plans had not all been regularly reviewed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Where people had concerns they were made aware of how to access the complaints procedure and this was available in the information guide given to people. The complaints policy gave information to people on how to make a complaint, and how this would be responded to. The policy set out the timescales that the representatives of the service would respond in, as well as contact details for outside agencies that people

could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. Care staff told us they would direct people to raise any issues that they may have directly with the manager.

We looked at how people's concerns and complaints were responded to, and asked people what they would do if they were unhappy with the service. People told us that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. However, the feedback was varied as to if people were satisfied with the response they received. One person told us, "I asked them not to send one carer, in my opinion he didn't have finesse. They haven't sent him back." Another person told us, "I raised complaints about the three nights they missed in a row. They followed it up and they got a rollicking. Recently I was asked if everything is okay." However, some people consulted considered that their concern/complain has not been fully addressed One person told us, "Yes I have, they keep apologising and they say they will come see me but they never do, so I take it with a pinch salt." Another person told us, "I have already raised this with the office that when some carers empty my commode they do not always wear gloves and then give me my lunch. One carer raised it with the office and it was brought about in a meeting. It has improved but some carers still do this I think it needs to be reinforced." A third person told us, "I talked to them about meals and missing calls they do nothing. I have made complaint. They just said I will pass a message to the staff for this to be done better. It didn't happen it didn't improve." We discussed this with the registered manager who acknowledged some complaints had not been fully dealt with. They had been going through any complaints received and had ensured these had been fully investigated and completed. This as an area of practice which is in need of improvement.

Requires Improvement

Is the service well-led?

Our findings

People's responses when asked if the service was well led was varied, and comments included, "I think so," "Not particularly, four months ago we got a letter to say the area manager was leaving, and the branch manager just walked out two months ago. I don't know what the current situation is," "No I think it is disorganised chaos," and "Not office wise, they haven't got a manager at the moment." A relative told us, "No the office, no." One member of staff told us, It's a shambles here and really unprofessional. Communication is terrible. You raise something and nothing gets done. People are just getting the care they are given." One member of staff told us, "Since (Registered manager's name) has been here, I see that improvements have been made." Another member of staff told us," I can talk to (Registered manager's name) about anything, she's on the ball." A third member of staff told us, "I can speak to (Registered manager). It's improving since she's been here, but I don't know how much time in the week she is here. The current management arrangements did fully support the operation of the service. Quality assurance systems had not all been maintained and were not fully embedded in the service. These are areas of practice which are in need of improvement.

There had been a number of changes in management arrangements in the office and office personnel. The registered manager was covering two of the provider's services. They told us the provider was in the process of recruiting a new manager dedicated to manage the office. Although contactable when not on site they were only in the office two days a week. People and care staff were not all clear of the management arrangements for the service. Staff told us support and communication was poor in the service. For example, "There is no management and no seniors to support us. We need that and we need travel time on our rotas." Another member of staff told us, "Once you actually get to the person, they receive good care. It all comes back to the office and lack of management." A third member of staff told us," The communication is none. Even if service users ask questions, we can't answer them as we nothing from the office. A fourth member of staff said, "There's not always someone to answer the phone when you ring the office and that's important. You can be stuck at the door and not be able to get in and you're not supposed to move on to the next call without the office knowing and ringing the client for you." This is an area of practice which is in need of improvement.

At the time of the inspection the formal systems of quality assurance to monitor the standard of the service provided had not been fully maintained and embedded in the service. Some checks of quality were taking place, for example, the medication administration records (MAR) for any recording errors. However, the audit system in place did not ensure errors in recorded were followed up in a timely way. Reviews of peoples care and support plans had not been fully maintained, care staff had not had a regular appraisal and supervision or spot checks carried out to ensure the quality of the care provided. Any incidents and accidents had not all recorded. So the registered manager and the provider had not been able to keep an overview of these to monitor any patterns in incidents, the quality of the care provided and provide guidance and support where needed. Systems were not in place to identify if there were any missed calls so this could be rectified. The registered manager was unable to show us a business continuity plan which would be used in the event of an incident. For example, in the event of bad weather or a breakdown of resources at the office. We found we could not identify how the provider monitored or analysed information

over time to determine any trends or concerns, to create learning and to make changes or improvements to the service where required.

Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. The information gathered from regular audits and monitoring over time is used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. This as an area of practice that is in need of improvement.

People were placed at risk as the provider did not have effective systems to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures were in place for staff to follow. Senior staff were able to show us how they had sourced current information and good practice guidance, which had been used to inform the regular updates of the services policies and procedures.

The vision and values for the service was recorded for people to read, and discussed with new care staff in their induction. The aim was, 'To respect our customers' privacy, dignity and lifestyle in the way we work with them. Our care will be provided in the least intrusive way possible. We will treat the service user and everyone connected with them with courtesy at all times. Our workers are sensitive and responsive to race, culture, religion, disability, gender and sexuality and that of the service users family and representatives. Our ethos is to carry out tasks with the customer rather than for them wherever possible, to help maintain independence and autonomy.' Staff demonstrated an understanding of the purpose of the service, the importance of people's rights and individuality, and an understood the importance of respecting people's privacy and dignity. All the feedback from people and care staff was that they felt comfortable raising issues and providing comments on the care provided in the service

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. We discussed this with the registered manager during the inspection, who demonstrated an understanding of their responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care calls placed people at risk of receiving late calls, or having their calls missed altogether. People were at risk of not receiving the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. This was because care plans had not all been regularly reviewed.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk as care was provided by care staff who not receive the supervision and appraisal they needed to support them in their role, and to help ensure the quality of the care provided.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were placed at risk as the provider did not have effective systems to monitor and improve the service.