Agincare Live In Care Services Limited

Agincare Live-in Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on the 16,17, 23,24,26, 27 February 2015 and 3 March 2015, we continued to undertake telephone interviews until 17 March 2015. The inspection was unannounced. Agincare Live In Care Services provides care to people in their own homes. They provide live in care staff to support people with personal care needs throughout England and Wales. At the time of our inspection there were 164 people receiving care, although this number changes regularly.

At the time of our inspection there was not a registered manager in post and whilst the current manager had applied to become registered there had not been a registered manager in post since July 2013. 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.

When we last inspected this service in July 2014 it was registered at a different location. Due to a re-location of the office the provider in December 2014 re-registered to provide a personal care service from its current location. When we inspected the service in July 2014 we had

Summary of findings

concerns about how people were cared for, how they were protected from abuse, how staff were supported, how medicines were administered, how consent to care was sought, how the Care Quality Commission were notified of important events, how risks were identified and managed and how quality was ensured. We asked the provider to take action about these concerns and they sent us a plan detailing that they would have addressed them all by the end of January 2015. We followed up on these up the areas of concern at this inspection because they related to the regulated activity of personal care and not specific to the location the service was managed from.

At this inspection we found that some improvement had been made but that these were not sufficient to ensure people's safety and welfare. People who had regular live in staff and were able to confidently direct their own care or had relatives who could support them with this were largely happy with the support they received from the service. The risks centred on people when they did not have regular live in care staff and or were not able to direct their own care.

People were not protected from avoidable harm because the systems in place were not effective in monitoring their well being. Investigations into complaints and incidents did not always lead to a reduction of risks because they were not detailed enough. People's care plans were not always adequate to ensure safe and appropriate care. Medicines were not always recorded accurately and this put people at risk.

People could not be confident of receiving care from appropriately skilled staff. Staff provided did not always have the skills necessary to meet people's needs and they did not receive adequate support and supervision.

The provider was not learning from incidents and complaints in a way that reduced risks to the health and welfare of people and live in staff and ensured on going improvements. The new manager was liked and respected. Changes had been made but these were not adequate to reduce risks and raise quality of the support people received.

Some people experienced personalised positive care when they were happy with the live in staff in their home. There were examples of this making profound and valued changes in people's lives.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 corresponding with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to protecting people from harm, staffing, medicines administration and the how quality and risks are monitored . We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not protected from risks of harm and abuse, medicines were not always administered safely and there were not enough skilled staff to meet people's needs.

When harm was identified this was not investigated in a way that would reduce the chances of it being repeated.

Is the service effective?

Inadequate

People were not always cared for by staff with the right skills, training and support to meet their needs.

People were not always protected from the risks associated with of eating and drinking.

People's consent to care was not always sought in line with the Mental Capacity Act 2005.

Most people told us they had support to access healthcare and maintain their health.

Is the service caring?

Requires Improvement

The service was not caring because it was not able to match people's support needs with live in staff effectively.

Some people received personalised support at the end of their lives, however not all people who may have wished to express their wishes about their end of life care had been asked how they would want to receive this care.

Some people experienced warm, supportive relationships that promoted their independence and dignity where regular live in staff, that they had chosen, provided care.

Is the service responsive?

Requires Improvement

People's needs were not reassessed when their support needs had changed.

People did not always receive care and support in a way that reflected their likes and wishes when they were not well matched with their live in staff.

Complaints were not always investigated and reviewed in a way that would lead to improvements in the service.

Is the service well-led?

Inadequate

Risks inherent in the service were not clearly identified and therefore plans to reduce these risks could not be adequately made.

Summary of findings

The manager and deputy manager were well liked and respected amongst staff who saw the changes being made a positive. This meant that where improvements were made they had been accepted and supported by the staff team.

Agincare Live-in Care Services

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 unannounced inspection took place in the office on the 16, 17, 26 February 2015 , we also undertook home visits and continued to undertake telephone interviews until 17 March 2015.

The inspection team consisted of four inspectors . Inspectors visited the office, visited people in their homes and undertook telephone interviews with people using the service and staff.

At the time of our inspection there were 164 people receiving care and 379 staff recorded as available to work.

During our inspection we spoke with 31 people who used the service, 13 relatives of people we didn't speak with. We also spoke with 23 live in staff, and 17 staff with coordination and management responsibilities and the manager and senior management from the provider.

We looked at the records relating to 22 people's care and eight people's medicines. We looked at ten staff records and records relating to the management of the service such as complaints and compliment records, safeguarding records and policies and procedures.

We also spoke with two social workers, a professional with safeguarding expertise, a health care professional and two social care professionals.

Before our inspection we reviewed information we held about the service. We did not have the Provider Information Return (PIR) available as the provider had not been asked to provide this information at the time of our inspection. (The PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.) We gathered this from other information we held about the service including notifications of incidents since the last inspection. (A notification is the form providers use to tell us about important events that affect the care of people using the service.) We considered the action plan that the provider had sent us after their previous inspection. During the inspection we gave the provider opportunities to tell us what they did well and what they planned to improve.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2014 we had concerns about how the service kept people safe from harm and abuse and how medicines were administered. There were breaches of regulations 9, 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. We asked the provider to take action to improve the service people received. At this inspection we found improvements in how CQC were notified of allegations of abuse. Whilst improvements had been made in relation to notifying us of abuse allegations we remained concerned about how medicines were administered and how people were kept safe.

People were at risk of not receiving their medicines as prescribed. We found there had been improvements in the recording of medicines administered by the live in staff since our last inspection and people told us that their medicines were well managed. For example, one person told us that their live in care staff was "very particular" with their medicines. We saw evidence that a live in care worker had been determined to be competent to administer a person's insulin by a District Nurse. Another person's relative told us that the regular live in staff understood the variable dosage of medicines their relative required.

Five people's medicines were managed safely, however there were errors in the management of three other people. One person had creams applied daily by their carer but the record of what cream should be applied was not accurate. This person had a review of their care in January 2015 and this error had not been noted nor their care plan amended. There was a risk this person's skin condition would deteriorate if they did not get the creams they were prescribed. Another person was prescribed a medicine (Oxygen) that required specialist training. The live in care staff working with this person had not been trained in how to administer this medicine safely. There was a risk the person would not receive this medicine if they needed it. There were gaps in this persons medicines records in February 2015 and it was not possible to know which medicines they had taken. Another person was prescribed a medicine to be used when necessary for a heart condition. This medicine had not been added to their medicine administration record and there was a risk they would not be given it if needed. This was a continued breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of receiving unsafe care as staff did not always receive appropriate information regarding people's individual risks. Staff did not always arrive at people's homes in time for an appropriate and safe handover. For example, during a home visit staff arrived two hours late for a 24 hour handover and therefore were not able to shadow how the person should be supported at lunchtime. On a separate occasion this person was supported by staff who were unable to undertake parts of their personal care because they had missed the handover. Incident records showed that another person had become distressed and had hurt a member of staff. The person had dementia and had returned home to a different member of staff.

The importance of handover between staff in providing a safe service was acknowledged by the deputy manager and manager, they told us handover records were sent into the office. However, they were not aware of the examples we found. The service was not being delivered in a way that ensured the handovers happened effectively to ensure safe care.

One person had told us that they experienced risks when in the community due to their eyesight. Whilst a review in January 2015 had described their eyesight as "deteriorated" their health and welfare form identified their sight was satisfactory. The person and their regular live in staff identified that their eye sight meant they needed support to stay safe when outside of the home. This was not reflected in their care plan and there was a risk that this could put them in danger.

During our inspection in July 2014, we identified risks related to the use of oxygen in another person's home and these remained unassessed at the start of this inspection. An emergency review was carried out of this person's oxygen use in respect of environmental risks that it posed, however this review did not result in the member of staff placed in this person's home knowing how to use the oxygen safely and as we have highlighted this put the person at risk of not receiving oxygen when they needed it. This was a continued breach of regulation 9 of the Health

Is the service safe?

and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was also some evidence of risks being identified and responded to appropriately but this was not consistent. For example a person had had a number of falls and this had led to medical input and a change in their care plan to reduce the likelihood of harm. Live in staff described how they identified and reduced risk on a daily basis. One live in care staff said: "I distract them when I need to and talk about other things they enjoy."

Most people told us they felt safe. One person said: "I've always felt safe." Another person said that they , "No one has ever treated me badly." We also heard from five people about times they had not felt safe, these related to the competency of staff to undertake tasks such as moving and handling. Although one person also referred to how a member of live in staff had "rather frightened me with her temper". Staff were able to describe how they would report any concerns to the management of the organisation. One live in staff said: "If I felt another carer had made a client unhappy or unsafe I would report it." Some live staff gave us examples of when they had done this and we saw records of these concerns.

Allegations of potential abuse were not always appropriately responded to. For example, a concern was raised by a member of staff identifying that a person had indicated they had not been treated with dignity in relation to their personal care. The provider's investigation ended when live in staff refuted the allegation. There was no referral made to the safeguarding authority responsible for investigating the abuse of vulnerable adults. We spoke with the member of staff responsible for this investigation who told us they had not spoken to the person concerned in order to clarify the allegation.

An other allegation of abuse had been made by a member of staff and this had been alerted to the appropriate authorities. A police investigation was undertaken that did not progress and the service were then asked to undertake an internal investigation. The records show that two parts of the allegation were not addressed during the provider's investigation, relevant people were not interviewed, and when we discussed the investigation with the staff member responsible they acknowledged that these allegations had not been investigated. In both examples the live in staff who were alleged to have acted abusively were returned to work. Spot checks, in which they receive an unannounced visit to check on their practice, where scheduled. No further risk management plans put in place.

The provider's policy on safeguarding vulnerable adults details that a root cause analysis should be undertaken when abuse is suspected or alleged and the provider is requested to undertake an internal investigation.This analysis is designed to ensure that all possible explanations are identified and responded to reduce the risk of further harm. This includes gathering feedback from all the parties involved. This process had not been followed and this contributed to the risk that people would experience avoidable harm. This was a continued breach of regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 (1) (2) (3), (4) (a) (b) (c) (d), (6) and (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence that the provider had responded appropriately when that abuse was substantiated by the local authority safeguarding investigation. For example, a live in staff member had lost their job after they left a person unattended and a fire broke out in their home. Another care worker had lost their job after being drunk in a person's home.

There were not enough suitably skilled live in care staff to ensure that all people received the care they needed. People told us that replacement carers were often arranged late without consultation. One person said referred to this as "eleventh hour", another told us "This is their business having the right person in place to provide the care to the person. It is always a rush and often they don't seem to be well matched." Another relative told us; "They know when (regular live in staff) is taking their break but it is still last minute." A social care professional also commented that this was an on going concern that caused distress to the person using the service.

There was evidence of the impact of difficulties in getting appropriate staff into people's homes. There were examples of live in carers being put into placement who did not have appropriate skills. For example one live in carer, without care experience, who had previously been subject of a complaint about their capability was allocated to provide support to a person with complex needs. The placement was not successful and further concerns

Inadequate

Is the service safe?

regarding their capability were raised. A relative told us that because of concerns over the skills of temporary live in staff they always visit more regularly when these workers were in the home. A temporary worker had been allocated who could not use the hoist. Records evidenced that another person complained to the provider about live in staff being unable to use their moving and handling equipment safely. A live in staff member who had been supporting a person who required support with moving and handling did not have a current competency assessment for this. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not have individual emergency plans to be followed if their live in care worker had to leave and or could not be replaced. The provider had developed a flow chart to be followed for all people receiving a service. This had recently been updated to involve improved communication with the person and their relatives if appropriate. The flow chart detailed utilising other domiciliary care or utilising a space in an Agincare care home if next of kin and local domiciliary agencies were not able to provide cover. The flow chart indicated that the local authority and managers of the service should be notified if there was no space in an Agincare home. This emergency flowchart did not provide an individual tailored plan to reduce the risks to the individual.

We discussed staff recruitment with the manager who explained that initial recruitment was done by a team of staff dedicated to this process, but due to the nature of the workforce the process included the successful completion of induction training. Most staff files contained evidence that checks had been made to reduce the risks of employing people who were unsuitable for care work. However, one live in staff member had not provided a reference that related to their most recent care work; a post they had not held for a long period. Another live in staff member had been employed abroad and their recruitment had been managed by a recruitment agency. There were gaps in their employment history and their references did not align with their CV. There was no evidence that this had been explored as part of the selection process. There was a risk that evidence that a candidate would not be suitable for the role was missed due to these omissions in the recruitment process.

A high percentage of the live in staff were overseas workers. We spoke with the manager about the processes followed to check on their suitability to work with vulnerable adults. The manager explained that these workers were subject to police checks in their home country when this was appropriate.

Inadequate

Is the service effective?

Our findings

At our last inspection in July 2014 we had concerns about how people's consent to care was sought, how staff were supported and how risks associated with eating and drinking were managed. There were breaches of regulations 9, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action to these aspects of the service. At this inspection we found that improvements had been made to how consent was sought and to the training and support of the staff who undertook new assessments and provided live in staff support. However, we had continued concerns about how the live in staff were supported to provide people's care and how people were protected from the risks associated with unsafe eating and drinking.

People continued to be unprotected from the risks of harm associated with unsafe eating and drinking. We found that a person who had previously been identified as at risk of choking had not been reassessed and continued to be at an unnecessary risk. They continued to eat foods that did not reflect the risks outlined in their care plan. We highlighted this to the manager and an emergency review was undertaken. When we visited the person their care plan had been updated to reflect that a relative provided meals, however the new guidance still referred to the person receiving a pureed diet when this was not the case. This indicated that the person undertaking this review was not familiar with the persons specific individual needs. The provider had not considered referring the person to a speech and language therapist to provide guidance and support with regards to developing a safe eating plan. There was no evidence that the risks had been discussed with the person.

Another person was identified as requiring their drinks thickened. They coughed following a drink whilst we visited, and we were told that they drank too fast and then coughed it up. The care records did not detail what consistency the person's drinks should be to reduce the risk of them choking. The live in care staff explained they had decided how much they put in each type of drink, however this was not based on a professional assessment. Another person's care plan stated that for clinical reasons their fluids needed to be restricted, there was detailed information about what foods would contribute to the total fluids allowed. There were no records available to evidence this had been monitored. We also found a discrepancy in the care plan of a person who had only recently started with the service. This discrepancy meant the care plan did not correlate with their safe swallow plan. The person's relatives identified this error when they saw a copy of the care plan but they did not know it had been completed two weeks after the assessment took place. People were not protected from the risks associated with eating and drinking as the support records /plans did not provide guidance to staff on how to support people safely.

People told us that they were mostly supported to access health care and to maintain their health. One person said, "They got the doctor." Another person described how they had: "sorted my dentures out". Some relatives commented on how confident they were in the live in staff's abilities to ensure their relatives health needs were met. One relative said, "Their (referring to the regular live in staff) medical understanding is exemplary. " However, we found examples of times when health input had not been sought appropriately . For example during our inspection a regular live in staff member returned to a person's home to find that they were behaving very differently to usual. They contacted the person's GP and it was discovered that the person had an infection that had not been identified by the temporary live in staff.

The above evidence was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy to ensure that staff receive the support necessary to undertake their roles. We found that this policy was not being followed because staff did not always receive their support sessions and when they did they were not always effective. The senior staff member responsible for scheduling staff support provided us with a list of staff whose support or training was out of date. These staff were in placement in a person's home or available to work. 34 staff were overdue an appraisal to review their professional development, 40 staff were overdue a spot check on their practice competency in a person's home and more than 40 staff were overdue a formal supervision session. After the last inspection the provider told us that all new staff would have a spot check in the first week of their first placement by 18 December 2014. Since 18 December 2014, 26 new staff had started in placement . 17

Is the service effective?

had not had a spot check within a week, two live in staff new to the service told us they had not had a spot check during their first placement. There was a risk that people would receive inappropriate or unsafe care because their live in staff were not supervised appropriately.

We discussed the staff support process with the staff responsible for undertaking these sessions with live in staff. They told us that whilst spot checks could include a requirement to assess moving and handling and medicines competency these checks were not usually booked at times when they could observe the staff undertaking these tasks. They explained that as a result these competency assessments were done through discussion. This was not an effective method to ensure competency . There was evidence that this meant staff were inappropriately assessed as competent in moving and handling. For example, one person whose regular live in worker was assessed as competent in moving and handling told us they pushed their wheelchair in an unsafe manner: "Most won't push me backwards (down the step/kerbs) I won't wear the belt in case they tip me."

Staff responsible for staff support and competency assessments told us they felt supported and were better equipped to undertake their role since changes had been introduced to their support and training. They had attended regular meetings and had all either had or were scheduled for a face to face supervision with the manager. They had also received training in medicines management, the Mental Capacity Act 2005 and manual handling. These improvements had not extended to the live in workers. Since our last inspection information about the individual live in worker was provided to the staff undertaking their staff support, however this remained inadequate to ensure effective support and development. For example, information relating to allegations of abuse was not passed on to the member of staff undertaking a spot check . Live in care staff did not receive the paperwork in advance of their supervisions or appraisals in order to prepare appropriately. The person supervising did not have access to information from the previous appraisal. The staff with responsibility for staff support commented on how this was particularly difficult in relation to training requests. One told us: "You don't know if they will get what they have asked for. You don't know what was said last time."

Further support was provided to live in workers by the staff who coordinated care form the office in the form of weekly calls. We heard from some live in care staff that they appreciate these calls. One said: "You can always call. It is a friendly ear." However, these calls did not always trigger additional support when there were indications that a live in worker was struggling. For example, a face to face visit was not offered or arranged where three workers indicated in the weekly call that they were dealing with difficult situations. The regularity of weekly calls was set as a process rather than as a response to the nature of support the live in staff might need. New live in workers, live in workers in complex placements, live in workers in geographically isolated placements did not receive more regular face to face contact from the service. One live in worker described a placement they had been in for over a month as: "very isolated area and I have no transport.. I could not leave the house at all". The importance of supervision was highlighted in the lone worker information of the provider's health and safety policy but the system was not implemented effectively.

People described staff skills as variable. One person described live in workers as: "varied –typically the care worker and their competency is totally variable". They said that: "My main carer has very good competency. But the ability to use equipment is varied and this is the major concern, one (live in staff) recently was particularly untrained ." One relative told us: "They need to have all the basic care skills and be able to cook and clean as a minimum." The ability to cook was highlighted as a concern by a number of people and relatives. One relative told us: "Cooking is an issue – not everyone knows how to cook the foods they eat." Another relative commented that they had had to teach live in staff to cook meals their relative liked. Live in staff received training in nutrition as part of their induction but their ability to cook was not assessed nor was training provided to meet any skill gaps. This meant that people who had an identified need to be supported with food and drink as part of their care plan were at risk of being supported by staff without the skills required to this.

Other skills were also identified as variable for example, people and relatives described difficulties with moving and handling skills and first aid. One relative described how a live in staff had not known how to respond to a choking incident . After induction, training was either provided in people's homes with respect of specialist procedures and competency assessments or by work book. 15 live in staff had not refreshed their health and safety training and this included the member of staff in placement in a home

Is the service effective?

where concerns had been raised about environmental safety. 39 staff had not refreshed their infection control training, this included two staff who had had concerns raised about their cleaning standards. 36 staff had not refreshed their medicines training this included a member of staff whose medicine administration had been the subject of a complaint. These staff were in people's homes providing care or available to work. The above evidence constituted a continued breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understanding of the MCA 2005 had improved since our last inspection. All staff undertaking assessments understood the importance of capacity assessments and best interest decisions in ensuring that people received their care within the framework of the law. There was evidence that consent had been gathered appropriately in some care records. However, we found that there was continued confusion around the power of attorney (POA) role and this meant that decisions were still being referred to people who did not have the legal right to make them. For example, one person who had capacity had signed their own care plan. This had then been amended and signed by their POA who was only legally allowed to make decisions related to the person's finances. Another person's POA for finance had signed their care plan, although the person was assessed as having the capacity to do this. We asked to see copies of people's POA information. The service needed this information to enable them to check what decisions a person's POA had authority to make. This information was not available for one person whose POA regularly made care and welfare decisions. Contact with the local authority regarding this person indicated that the POA is not able to make health and welfare decisions legally and as such should only be consulted as part of best interest decisions along with other relevant people. We also found that best interest decisions had not been made around restrictive care practices in place to keep a person safe from risks associated with their behaviour.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in July 2014 we had concerns that people were at risk of receiving inappropriate care at the end of their lives. There was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action to reduce these risks. At this inspection we found that improvements had been made to how end of life care plans were recorded, however some people had not been asked about how they wished their care to be at this time and people described how difficulties associated with not getting on with some live in staff.

We looked at the records related to four people's care who had used the service at the end of their lives. When care plans had been drawn up to specifically provide end of life care they were clear about people's life wishes and specific decisions regarding whether a person wished to be resuscitated if their heart stopped were recorded clearly. Where people had active involvement from family members their input was recorded. Compliments from the relatives of people who had died reflected an appreciation of the right live in worker providing quality care at the end of people's lives. However not all care plans had detailed information about end of life wishes or evidenced any discussion about this. We spoke with a member of regular live in staff who did not know if the person they were supporting had any wishes about how they wished to be cared for at the end of their life. There was no record that this had been raised with the person and it would have been appropriate to address this based on their current care needs. There was a risk that people who had not accessed the service specifically for end of life care might not receive such care in the way they wanted.

Where people had regular live in care staff who they got on well with strong, positive caring relationships were evident. One relative highlighted the importance of these relationships: "The agency is just a name it is the carers who are the people." A person told us how confident the relationship they had with their regular live in staff made them, whilst describing an uncertainty about when staff would arrive to cover the regular live in staff's break. They told us: "She wouldn't have gone. She is loyal like that." Another person told us :"I am happy with the service it is very very good care." and "I have had the same person (live in staff) for a long time they know what I need." When the person had a regular live in staff we saw evidence of the strength of relationships in shared communication and humour. Positive relationships led to positive outcomes for people. For example, a person with very complex needs had begun to enjoy more experiences since a regular live in staff had begun working with them.

Some people described times that they had not felt a relationship had developed. One person talked about how some live in staff only spent time with them when they asked for help and this made them feel uncomfortable. The importance of communication was highlighted by a relative who described how when their relatives humour was not understood by the live in staff it affected their mood negatively. People told us that these difficulties were more common when live in staff and people had different cultures and first languages. The provider was a was aware of the importance of the relationship between live in staff and people and aimed to provide continuity.

The importance of good matching of staff with people and supervision in ensuring that people experience a caring service was evidenced through people's descriptions of positive and difficult experiences. For example one relative referred to the regular live in staff with their relative as: "wonderful, absolutely… made for us a nice quiet approach". Another relative described their relative's regular live in staff as having a: "faultless, a brilliant grasp of (person's) needs". However another relative described the difficulties associated with having a live in staff member who would cook food their relative could not eat, and another relative described how recent difficulties meant: "We feel anxious when (regular live in staff) is going on their break"

Most live in staff spoke confidently about how they support people to make choices. One staff commented their role involved the need to: "keep people as independent as possible". Another live in staff member described the ways they encouraged someone to keep control of their day to day life by offering opportunities for choice throughout. Live in staff were also able to discuss how people's dignity and privacy could be respected both in paying attention to respectful personal care and supporting their relationships. Staff spoke positively about the people they were working with and we came across examples of these staff giving thought and consideration to how to improve people's care and environment. For example one live in care staff talked about how important it was to maintain a quiet

Requires Improvement

Is the service caring?

environment and how they managed this and another member of staff described the changes they had made that had meant the person could broaden the activities they undertook.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2014 we had concerns that people were at risk of not receiving appropriate care because their care needs was not reflected in their care plans. We were also concerned that complaints raised by people did not leave to improvements in care practice. There were breaches of regulations 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action to these aspects of the service.

People were cared for in their own homes and their care was designed to be personal to them. However there was a continued risk that the care people received did not always respond to their needs. Care plans contained information about people's likes and preferences and gave individual history appropriately, but we found inaccuracies or omissions related to the care people needed in seven care plans. Where care plans were missing information live in staff sometimes provided this information to other staff directly. For example, a regular live in staff showed us the detailed information they left for temporary live in staff when they went on their breaks. The care plan of another person with complex needs did not provide detail as to how best to manage risks. We spoke with the live in staff and they explained that they had written their own "behavioural plan". Two members of staff described how they had improved the way they helped people manage their money safely but that this detail was not reflected in the people's care plans. Whilst this information was vital to assist temporary live in staff, there are risks associated with staff writing their own unchecked guidance as it may not be safe or reflect good practice.

Care records returned to the office and calls with staff in people's homes sometimes highlighted changes in people's needs that were not picked up and addressed appropriately. For example, we reviewed the care notes of a person which indicated that their dementia was having an increased impact on them. This was also highlighted in the weekly calls the office staff had with the live in staff. This did not lead to a review of care needs. Another person, who had complex care needs and needed staff support to move, was noted to be smoking again by live in staff during a telephone call with the office. This did not result in any update to the person's care plan or review of the risks they or the member of staff working with them faced as a result of this change. These people were at risk of receiving inappropriate and unsafe care because the care needs had not been reassessed appropriately.

Some people spoke about how they enjoyed activities with their live in staff. One person said "Excellent" as their live in staff described the activities they take part in. However the live in staff reported that they did not always get to do these activities when there was a temporary live in staff providing break cover. One person described the return of their regular staff as being: "Getting my life back." We spoke with people who described how they went out with their live in staff to do activities they enjoyed. Another person told us they rarely go out when they have temporary live in staff as they are often not confident with their wheelchair in the local community. There was a risk that when people were not well matched with their live in staff they would not receive care that was responsive to their needs. We discussed the matching process with the staff who allocate live in workers to people. They described the difficulties inherent in this process. "We try to meet with care workers – I go to see them on induction if it is held here at office. However yes, this is a challenge with a transient and remote workforce. We use the pen picture we are provided with but they're quite brief."

The above was evidence of a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were returned to the office and a selection of those returned were reviewed. Records included people's address and personal information and were sent by post to the office. There was no system for ensuring these records were checked as arrived safely or to protect the confidentiality of the person should the single envelope be damaged during transit. There was a risk that people's confidential information could be lost, or read by others, and this not be identified.

People had varied experiences of communicating with the office staff. Most people said they now had a named person and that when they called they got a response, but some people told us that communication sometimes went unanswered and they had to chase it. People had mixed views about expressing concerns. Some people were

Requires Improvement

Is the service responsive?

confident they would be heard. One person said: "I'd phone the office if I had any trouble.", another person told us: "I had a carer who was drinking. I phoned the office they dealt with it promptly."

The service did not learn effectively from complaints and concerns because they were not always investigated in line with the provider's expectation of 'root cause analysis'. We reviewed complaints received over the four months prior to our inspection. Some had been handled in a timely manner and concluded appropriately. However more complicated complaints were not fully investigated. For example, a family member shared a concern that their relative had not received appropriate health care and highlighted that their relative had not wanted to complain about aspects of their care whilst the live in staff remained in their home. The relative had been admitted to hospital following a delay in receiving prescribed medicines. They also detailed concern that records related to care and medicines had been completed retrospectively. The investigation notes did not address all the strands of the complaint. This meant that potential training needs of the live in staff concerned were not identified. Another relative complained about the care practices of two members of staff. During the investigation the relative was not contacted to clarify, or elaborate on, their concerns. There was a continued risk that information necessary to form a judgement was not gathered and that people's care was not improved by the complaints process. There was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to regulation 17 (1) (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2014 we found that there were systems to monitor the quality of the service and promote high quality care, however these were not effective, did not involve people consistently and drive up standards. The provider was not meeting the requirement to report information to the Care Quality Commission. There was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We told the provide to make changes to ensure improvements in this area. At this inspection we found improvements in the information provided to the CQC by the service, however the quality of the service was inadequately monitored.

The manager and deputy manager had joined the service since our last inspection and were aware of some work that was needed to improve the service. Staff who had contact with the new manager were confident of the changes being made and the direction of this change. Staff told us: "I feel listened to now." and "Our experience is being listened to." However, the manager and deputy's understanding of the service was partial and that they had not yet been able to fully assess the risks facing the live in staff and the people who used the service. The manager acknowledged that since joining the organisation they had been "fire fighting" and had not had the time to undertake a comprehensive review of the service.

The manager and deputy manager told us about the plans they had for the service but these had not been formalised or agreed with the provider. This meant that progress was not measurable or targeted or supported by the provider. We discussed a number of areas that had been improved for example, the manager told us that training was a priority for both the live in staff and the staff who undertook assessments and delivered staff support. We saw that resources had been made available for this and additional time had been allocated for this training with an additional day added to both inductions to consolidate learning. However, these changes did not directly respond to the continued concerns of people and relatives expressed during this inspection.

The manager described the one of main risks facing the service is the geographical location of work force. Whilst this was acknowledged the service did not have plan to address or review these risks. The manager told us they had begun to visit people and live in staff in their homes and had visited four people at the time of our inspection. They told us: "It is humbling how isolated staff are." The service responded to this geographical isolation by ensuring that office staff made weekly calls to live in staff and people receiving the service or their representatives. At our last inspection we identified that this was not an effective means of ensuring concerns and changes were picked up and addressed. There had been no analysis of the risks inherent in this method of quality assurance and we found further examples of it proving ineffective at this inspection.

We heard from a person's relative that they did not want to share concerns about a worker whilst they were in placement. This had been highlighted to the service as part of a complaint in November 2014 but not addressed. We also found that telephone calls where people or staff expressed concerns that did not lead to a response by the provider. In four instances staff identified changes in the needs of the person they were providing care and these were not followed up appropriately. For example, two carers reported a deterioration of abilities of the person they were supporting but no care review had been considered. This meant people and live in care workers were at risk of receiving and providing inappropriate care because the quality assurance system was not effective. Another telephone call record detailed a request by a person to investigate an alleged theft, but the person was not contacted by the service for over one month. A live in care staff identified concerns with other carers working in the person's property. The staff in the office had also recorded a conversation with this person's relative stating it is difficult to know what is going on because different carers are saying different things. There was no request made for a visit to be made to the live in staff to offer support or assess the situation and seek solutions. This meant a difficult work environment was not reviewed for the live in staff because the system did not identify the need for further action.

Safeguardings and complaints were audited to ensure that processes were followed but these were not effective. There was evidence of these audits and that missed actions were addressed as a result. There was no audit of this information to enable the manager and senior staff to identify risk factors. For example, people and relatives suggested that risks were higher when temporary live in staff or inexperienced live in staff were providing care. We

Is the service well-led?

found the quality of handovers and the stress experienced by live in staff was also indicated in information about incidents gathered during our inspection. These themes had not been identified because care delivery records, staff calls and personnel files were not routinely checked as part of investigations. Emerging themes were not explored to establish appropriate service responses. This put people at risk of continuing and avoidable harm.

Another theme that emerged through our inspection related to the ethnicity of the workforce. People told us about difficulties with language and diet associated with cultural differences of the staff supporting them were part of their experience of the service. For example, a member of office staff commented that sometimes issues arise because staff do not know local vegetables by name. Live in staff commented on experiencing racism, we also saw an investigation report where a live in staff had referred to racial abuse within their workplace and this was not picked upon by the investigating staff member. A member of staff responsible for matching live in staff with people commented that there was no clear policy to deal with this despite the large proportion of the workforce being overseas workers. We asked the manager what proportion of the workforce were not British nationals and they did not have this information. The impact of potential racism compounded by isolation in rural placements was not addressed as part of staff support. Health and Safety guidance encourages employers of migrant workers to consider language and cultural issues and the effects of attitudes of those they are in contact with.

Live in care staff were not protected from environmental risks or the risks associated with lone working Health and safety legislation stipulates that employers must assess the risks facing their work force. We spoke with the staff who assess new placements about the risk assessments they undertake when assessing a new placement. They told us they did not have guidance about the minimum standards required for their workers over and above the need for a private bedroom, but if they were concerned they would contact the office. This was also the detail provided to people buying the service. The guide stated : “The care worker will need their own room, bed and linen and somewhere to keep clothes. You will be expected to provide the resources for their meals following a ‘normal’ balanced diet.” We asked the staff undertaking environmental risk assessments if they checked the live in staff would have access to a phone or if they would get mobile phone signal. We were told this was not a specific check by all the assessors we asked. They also told us they had not undertaken any lone worker risk assessments.

We looked at the environmental checks made on a home where live in staff had declined work because of environmental issues. These issues had been acknowledged by the service with a social worker involved in the placement but the environmental check did not mention the associated risks. The provider’s health and safety policy details the importance of supervision for lone workers. There was no evidence that the risks of individual placements, or the workers own skills and abilities fed into support and supervision planning. A live in care worker had raised concerns about the safety of a home. This resulted in a phone call to a relative of the person but was not checked at the next visit to the person’s home by a member of staff with responsibility for undertaking assessments.

This evidence contributed to a continued breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we were concerned that people were not protected from avoidable harm because systems and processes did not join up around the individual person’s care and the individual staff support. At this inspection we found there had been improvements in ensuring spot checks happened for staff involved in investigations. However there were continued concerns where staffing issues had not been adequately addressed. For example a member of staff with no previous care experience, was placed with three people with complex care needs and there were concerns raised during or after each placement. No support or training was provided between these complex placements. This was evidence that risks associated with staff capabilities were not assessed or managed appropriately.

At the last inspection we had concerns that the provider was not meeting its statutory obligation to notify the Care Quality Commission of allegations of abuse. A member of staff had responsible for making these notifications and they were now made appropriately.