NR Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 7 July 2017 and was announced.

NR Care provides a domiciliary care service in people's own homes. The service was supporting 130 people with their personal care needs at the time of this inspection. NR Care supports older people, some of whom are living with different forms of dementia, people with physical disabilities and people with mental health needs.

The registered manager left NR Care a month before we inspected the service. There was an acting manager in place who was applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The nominated individual and provider were involved in the day to day running of the service. A nominated individual also has a legal responsibility for the service to meet the legal requirements and regulations.

At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the end of this report.

People were not always protected from the risk of harm or abuse. A person had made an allegation about a member of staff harming them, but the appropriate processes were not followed. No investigation took place to find out what had happened, and to ensure people were protected against this risk in the future.

People were supported by staff who sought people's consent before supporting them. However, the service was contacting health and social care professionals on their behalf without obtaining people's consent to do this. Staff were also making a certain decision on behalf of a person and restricting their freedom, without following the guidelines of the Mental Capacity Act 2005.

Complaints and concerns were not managed in an appropriate way to respond, address, and investigate what had happened and try and prevent it from happening again.

Systems were either not in place or the monitoring of the quality of the care and service provided was not robust. Audits were either not taking place or they were not effective in identifying where improvements were required. When issues had been identified there was no evidence to demonstrate that action had been taken to address these issues, to prevent them from happening again.

The nominated individual and the provider did not have a robust overview about the quality of the service provided and where the service needed to make improvements.

The CQC was not informed about a potential safeguarding event, which by law, the then registered manager or the nominated individual should have notified us about.

There were no effective systems in place for the office staff to follow if concerns were raised about staff practice, when they were supporting people. We found examples of when people had informed the service about potential concerns relating to the staff who supported them. Appropriate action was not taken to investigate, monitor staff, and address staff practices.

Staff knew how to identify if a person was experiencing harm or abuse in some way and knew to report this to the manager. However, staff did not know of the outside agencies they could also their report concerns to.

Plans to manage the risks which people faced were not always robust. These risks were not always identified and explored sufficiently when the service assessed people's needs. However, people told us that they felt safe when they received support from staff.

Staff had a thorough induction to their work, had regular training, and supervisions. However, the training provided did not always take into account people's specific individual needs. There were limited checks to evaluate the competency of staff, to ensure they met people's needs safely and effectively.

People told us that they received appropriate support with their food and drinks. However, we had concerns about one person who received support with their food and drinks, which we told the nominated individual about.

Staff were caring and kind to the people they supported. People also told us that staff treated them in a way which promoted their dignity and staff respected their privacy. People had formed positive relationships with staff who supported them and they had confidence in the staff's abilities.

However, this was not consistently the case. We were told by some people who used the service and their relatives about some examples of staff practice which were not caring. The way the service managed these situations did not always promote a caring culture at the service.

People told us that they saw regular staff, at times they were happy with, and they knew when and which members of staff would be visiting them on a regular basis. People rarely experienced late calls. All the people we spoke with said they would recommend the service to others.

People spoke positively about staff engaging with them, chatting, and involving them in their care. Staff were aware of the risk of people being socially isolated. The service was making plans to support these people in the future.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from experiencing harm.

Plans to manage risks were not always robust.

People said they felt safe with staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not always promote people's freedoms appropriately.

The service had not fully explored people's consent in relation to accessing health and social care services, on people's behalf.

Staff had a thorough induction and received regular training.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people received support in a way which was not caring. The way the management of the service responded to some events did not promote a caring culture.

People spoke positively about the staff they saw.

People's dignity and privacy was promoted by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints and concerns were not being responded to in a timely and robust way.

People received care that took into account their individual needs and wishes.

People were supported to avoid social isolation.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People's care records were not being audited in a robust way.

Staff competency was not being checked in a meaningful way.

Systems to monitor the quality and safety of the service provided were not adequate.

NR Care Ltd

Detailed findings

Background to this inspection

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

The inspection took place on 6 and 7 July 2017 and was announced. We announced this inspection because this service provides a domiciliary care service and we needed to seek people's consent to speak with them. This inspection was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone, who uses this type of care service.

Before the inspection we viewed all of the information we had about the service. The previous manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications about important events the registered manager or provider must tell us about by law. We also contacted the local authority quality assurance team, local authority safeguarding team, and the clinical commissioning group (NHS) to ask for their views on the service.

During the inspection we spoke with fourteen people who used the service and six relatives. We spoke with the acting manager, the nominated individual, and five members of the care staff.

We looked at the care records of nine people who used the service. We also viewed records relating to the management of the service. These included risk assessments, daily records, reviews, three staff recruitment files, training records, spot checks of staff, medication administration records, and audits.

Requires Improvement

Is the service safe?

Our findings

When we inspected NR Care we found that there were times the service did not promote people's safety.

A person made an allegation a month before we inspected the service, that a member of staff had physically harmed them and laughed. When we looked at the person's record and spoke with the nominated individual about this, we could see their relative had raised this issue with the previous manager. The nominated individual was not aware of this situation. The appropriate action was not taken to address or respond to this allegation of potential abuse. The previous manager had not contacted the local authority safeguarding team. The acting manager told us that the member of staff was taken off the person's rota. However, the staff member continued to provide care to other people the service supported without any investigation of their conduct. We discussed this with the nominated individual who then took appropriate action and contacted the safeguarding team.

The above concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected against experiencing harm. We spoke with one person and their relative who told us about a situation when they felt a member of staff had scratched them accidently. Two other people told us they felt they had experienced bruising when they were being supported to have a wash. People said these were accidents and these people had not informed the service about these incidents. However, the service had not created systems to enable these types of events to be passed to the manager to enable them to take appropriate action and robustly monitor these types of incidents.

One of these people had spoken with the service about a member of staff, and the member of staff had been taken off their rota, so they did not support this person anymore. They did not give specific reasons and this was not checked by the service. We later saw an entry in the service's computer system that this member of staff was refused entry into the person's home, but the member of staff challenged this person's relative about entering the property. This was also not addressed by the previous manager. This member of staff's performance was not closely monitored after these events.

The staff we spoke with told us how they would identify what potential harm and abuse looked like. They all said that they would call the office to raise any concerns that they had. Out of five members of staff two of these knew about the local authority safeguarding team, who they could also report their concerns to, if they felt the need to. However, these members of staff told us that they knew this information from their previous jobs. The other care staff did not know of this team. When we asked staff if they had the contact details of the CQC and local authority safeguarding team, most were not sure if they had this information.

We looked at a sample of people's care assessments. These did identify and in some situations explain the risks which people faced. However, in all cases, the risks which people faced were not fully explored. This meant there could be times when these people were not safe. One person smoked a high number of

cigarettes each day, they also experienced periods of confusion and memory loss. To manage this staff were limiting how many cigarettes this person smoked. The service had not created a meaningful and robust plan and taken action to manage this risk. For example involving housing, social services, and the fire service. A robust plan would have guided staff about what to do if they felt this person was putting themselves at risk.

Some people had clinical diagnoses of mental health conditions. We looked at these people's plans and they had not fully explored the risks which these people faced and how their mental health needs impacted on their physical and mental wellbeing. There was a lack of guidance for staff about how to support people safely in a mental health crisis. What might be the symptoms for individuals that they were unwell, and who should they contact, if they had concerns, was not explored.

We looked at one person's daily notes who lived with dementia and had experienced a series of falls. They had two falls in one day and a further two falls over the next two weeks. Action was taken on the first fall in terms of contacting a district nurse; however this was to respond to an injury the person had sustained. No action was taken to address the fall itself. This was not discussed with the person, or their relative. Social services was not contacted in this person's best interest and informed of this new risk.

We identified one person who was not able to leave their home in an event of an emergency and one person who smoked a high number of cigarettes who was living with dementia. The service had identified at people's assessments if there was a working smoke alarm and where the fire exists were. When we asked staff what they would do if there was a fire in the person's home who was unable to leave, three members of staff did not know what they should do. The examples they gave could have put them and the person at risk of harm. For the person who smoked cigarettes there was no meaningful plan in place to try and prevent a fire or what action they needed to take, if there was a fire during a care visit. We concluded, these potential risks had not been fully considered, before we asked the question. Staff should have had training or a conversation about what to do in these situations, but this had not happened.

When a person started to receive care visits from NR Care a member of the office staff would visit them in their homes to complete an assessment of need. This included an environmental assessment. When we looked at people's care records we could see that safety assessments had been completed in relation to the condition of a person's home. The assessments identified if there were issues with people's electrics and where people's utility supplies were located. In some cases the staff's safety in accessing the property was considered. These assessments are important to ensure people and staff were safe. However, we noted that in one person's environmental risk assessment from the sample we looked at, the risks were not always identified, with a plan in place for staff to follow.

The nominated individual had a contingency plan in place. They talked us through the various systems and plans that were in place. These plans were to enable people to still receive care visits if there was a disruption to the service. For example, in extreme weather conditions, if the staff group was suddenly reduced in size, and if there was an electronic power failure affecting records and staff rotas.

We asked people about their views on staffing levels. One person said, "Yes they do now, one or two left a while ago but it has fallen into place nicely." Another person said, "There are enough [staff] for me."

The majority of people we spoke with said they saw a regular group of staff, who visited at times they were happy with. When staff were late, people said they received a call or they did not mind waiting. People told us that they did not feel rushed and staff stayed their allotted times. People who needed two members of staff to assist them said they always received this level of support.

During the inspection we asked people if they felt safe with staff. One person said, "Yes they [staff] are very good and tell you what they are doing." Another person said, "Very safe because they [staff] are very good and reliable." A relative told us, "Yes I trust them [staff]."

We looked at the recruitment practices of NR Care. Staff had completed a Disclosure and Barring Service (DBS) check to ensure that new staff were suitable to work in a care service. All the staff we spoke with confirmed this check was in place before they started visiting people in their homes. We also reviewed a sample of staff personnel records and we could see that staff identities had been checked. These members of staff also had two references each.

However, we noted that two members of staff records out of the three we looked at did not have full employment histories. Staff's application forms did not ask for a full employment history and for gaps to be explained. This is another safety check to ensure people were safe to work in care. The services' PIR report stated that gaps in employment were being checked. However, the service was not doing this. We concluded that improvements were required to ensure recruitment processes were safe.

People told us that they felt staff administered their medicines in a safe way. One person's relative told us, "The care workers administer the medicines, yes they are received on time and they fill out the chart and they count the number of pills left." A further relative said, "NR Care gives [relative] their medicines before food and mark the chart afterwards."

However, the service was not auditing people's medication administration records (MAR) on a regular and frequent basis. Staff were not receiving regular competency checks in relation to administering people their medicines. So the service could not always be certain people were receiving their medicines, according to best practice and as the prescriber had intended.

Requires Improvement

Is the service effective?

Our findings

The staff did not always understand how to support people who may lack the capacity to make specific, informed decisions about their care. The service was not always compliant with the Mental Capacity Act.

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

We found that the staff were restricting how much one person smoked. The previous manager or nominated individual had not followed a best interest process under the MCA. They had not consulted with the person, their relative, a health or social care professional to reach a best interest decision for this person. We noted that there were times that staff found this person agitated and anxious about their lack of cigarettes.

People were also not being asked for their consent to share their information with health and social care professionals. We were shown records which confirmed there were times office staff had done this, but they did not have people's express consent to do so.

When we looked at people's care and assessment records we noted that people did not have robust capacity assessments. The service did ask people for their understanding about why they were having care visits. There was a statement in people's care assessments and plans which asked if the person felt they had capacity. However, this is not an assessment of a person's capacity. Furthermore, in the sample of assessments we looked at these questions were not always answered. Some people were living with different forms of dementia and long term mental health conditions, these people did not have a capacity assessment.

The above concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with told us that they offered people choices and always sought people's consent before supporting them. Staff gave the examples of offering choices with food and drinks, and with people's personal care routines. The people we spoke with confirmed this was happening.

During our inspection, we asked people about their views on whether staff who supported them had the skills and knowledge to do their jobs well. We had a mixed response.

One person said, "Most of them do (have the skills to do their job), on the odd occasion only this week there was one very young one who didn't know what [they] were doing." A relative said, "That is difficult to answer, most of them are, but one or two who come and haven't dealt with [relative] before, should have read the

care plan, but they don't always do this." A further relative also told us that, "In the early days there were young carers that weren't experienced enough, but other than that they [staff] are efficient and do their job properly."

Alternatively, people also spoke positively about how effective staff were who supported them. One person said, "They know what they are doing." Another person said, "Definitely yes, they [staff] know what to do when washing, grooming and looking after me." A relative told us that, "They [staff] are definitely trained, they have to attend training, and they [staff] meet my [relative's] needs."

The staff we spoke with spoke positively about their induction to their job. New staff had five days training in the class room provided by a trainer who was employed by the service. Staff told us and we could see on the days we visited the service's office that this training was also interactive and practical. Staff told us that they felt comfortable asking questions and for the trainer to repeat areas of the training. After this period of classroom induction staff had two days of 'shadow shifts' with more experienced staff. The staff we spoke with felt this was sufficient and this induction process had prepared them for the work ahead.

We saw records which confirmed that staff completed the 'care certificate' which is a set of standards which outlines what good care looks like, during this induction process. Individual members of staff were then observed in a person's home to see if they were putting this training into practice.

Staff received training on first aid, dementia awareness, medication administration, moving and handling, MCA and safeguarding. Staff also told us that they had received training supplied by a qualified nurse to support people who used specialist equipment. Staff received refresher training each year, which was also classroom based. We saw this refresher training taking place on one of the days we visited the service's office.

However, staff had not received training in other subjects relevant to people's needs, such as mental health, diabetes, and emergency evacuations. Staff had also requested training in 'end of life care' but there were no concrete plans in place to provide this.

The staff we spoke with said they had regular supervisions and they found these helpful. The service supported a wide geographical area. The service had open sessions weekly at locations in these areas. This is when a member of the office staff would be available to talk to staff in an informal basis, if staff wanted to do this. However, this was only for an hour or two at lunch times. We spoke the nominated individual who said they would make plans for these open sessions to be at times when staff were less busy.

We concluded based on this information, the lack of staff competency assessments, the issues which some people had raised about staff, that there were times, staff practice required improving.

People told us that they were supported to have sufficient to eat and drink. One person said, "They [staff] make my lunch, they know what I like, they ask if I want a sandwich, they are excellent." Another person said, "Yes they [staff] get me something for tea and cereal for breakfast, yes a choice is offered." A relative told us, "Yes [relative] is offered a choice, they let her know what is in the fridge."

Out of the sample of people's records we looked at two people had complex needs with eating and drinking. One person's care plan gave clear instruction about how to support this person with their eating and drinking needs and what to do if there were issues, and what those issues could look like. There were also contact numbers of the health professionals involved with this person's eating and drinking needs.

However, we looked at another person's record regarding their eating and drinking needs and there was limited information to guide staff about this person's needs in this area. For example, we looked at one person's record who was living with dementia and who often refused to eat, stating they had already eaten. We noted in their care notes that staff had on occasions verified if this was correct. However, we also noted that there were other times, which were more frequent, when staff had not recorded if they had done this, or they found no evidence of this person having eaten, and they had not taken action. Staff should have spoken with the person, or shared their concerns with a relative or with the manager. In this person's care plan there was no guidance for staff to follow when this situation happened.

The people we spoke with told us that staff advised them to seek medical and health intervention when there was a need to. One person said, "Yes and yes they contact people if needed." A relative said, "They [staff] are always alert to different things and tell me."

The staff we spoke with gave examples of when they have had concerns about a change in a person's health needs they had spoken to the person or their relative. Staff gave us examples about what action they took to prevent a breakdown in a person's skin from happening, for those people who spent a lot of time sitting or lying in bed. The people we spoke with and their relatives also confirmed this happened.

Requires Improvement

Is the service caring?

Our findings

We found that there were examples which demonstrated that staff were caring and kind towards the people they supported. However, there were elements of people's experiences and how these were managed by the service, which were not caring. Therefore some improvements were needed in this area.

One person said they had been harmed once when receiving personal care. We also found that it was unclear if staff were supporting a person to have something to eat, who was confused at times. They had also withheld their cigarettes which had distressed this person. Again these practices cannot be considered to be caring. One person had recently phoned the office to say they had had some missed calls. Following an investigation by the nominated individual, this was found to be true.

During our inspection we asked people if the staff who supported them treated them in a kind and caring way. One person said, "Yes because they [staff] always put you first…and take their time." Another person said, "Extremely the way they [staff] come over, they give the impression that they do seriously worry about me, it is reassuring." A relative told us, "Yes, because of the different things they do, like put a hand on my [relative's] shoulder and say bye, even though [relative] isn't aware."

We spoke with the acting manager who told us about a person living with dementia and whom a member of staff had visited the morning of our second visit to the office. Their battery of their wrist watch was no longer working, this had confused this person, to the point they were changing the other clocks in their home, to match the time on their wrist watch. The acting manager had advised the member of staff to purchase a new battery for their watch that morning. We later heard a member of the office staff confirming this had happened, and the person's wrist watch was now working. Staff in this situation had responded in a caring and thoughtful way to support this person.

The staff we spoke with said that they did see regular people. They spoke about how important this was to build positive relationships with people. Staff also said it was important in order to get to know individuals and learn how these individuals wanted to be supported. Staff were able to tell us about the people they supported, what their preferences were and their backgrounds.

People told us that they were involved in the planning of their care. One person said, "Yes the lady came and asked what I needed and I got it." Another person said, "Yes I do feel involved." A relative told us, "Very much so, I talk to my [relative] and I liaise with NR Care."

When we visited the office we found that people's confidential information was stored in a secure place. The staff we spoke with talked about the importance of protecting people's confidential information. However, we found that a relative had raised concerns about two members of staff discussing other people who used the service, in front of their relative. They raised this with the manager at the time, however, it was unclear if appropriate and robust action had been taken to address and prevent this breach in confidentiality happening again.

People told us that they were treated with dignity and respect. One person said, "They [staff] are extremely respectful." Another person told us, "I'm not the sort of person who would accept not to be respected." A relative said, "100 per cent, they [staff] are extremely respectful."

The staff we spoke with told us how they promoted people's dignity and privacy when they were supporting people with personal care. Staff gave examples of when they gave people private time and checked it was okay to return to them. Staff also said how they spoke to people to ensure they were happy with the support they were receiving. All the people we spoke with confirmed this practice.

Requires Improvement

Is the service responsive?

Our findings

We found that the service was not responsive or person centred in how it responded to complaints and the concerns raised by people and their relatives.

During the last two months we had followed how one person's complaint was being handled by the previous manager. After speaking with the previous manager and looking at their records regarding this complaint, due process and the service's own policy had not been followed. We spoke with the nominated individual who told us that the local authority needed to prompt the service to respond to the complaint. There was also no conclusion regarding an element of this person's complaint; this was an item of their property, which they say a member of staff had broken.

At the inspection we looked at a sample of care records and we noted that three people had raised a concern or a complaint about a member of staff. No complaints process was followed to investigate the issue and complaint, consider appropriate action, and advise the person making the complaint or raising the concern about the outcomes.

The above concerns constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt they did receive care which was responsive to their needs. People felt involved in their assessment and planning of their care.

The people we spoke with said they were consulted with in relation to their preferences of the gender of the care staff who supported them. One person said, "Yes they do (ask for my preference), I only have females, no they have never sent males." Another person said, "Yes (I was asked about my preferences) I only have females."

People also told us that they generally saw regular staff and at times they had either chosen or they were satisfied with. When people were unable to see their regular members of staff people told us that the office phoned them to advise them of this. The people we spoke with were not distressed or unhappy about this. People also said that if their member of staff was running late, they were also told about this. People said that they were happy to wait.

We looked at a sample of care assessments and care plans. These did not include the times that people had chosen for their care visits. However, the information and detail of these plans demonstrated that the service had spoken with individuals and asked them how they wanted to receive their care. In terms of the care tasks which people wanted support with, in the sample of care assessments and care plans we looked at, there was detailed step by step information about these tasks. The care plans we looked at were unique to individuals.

One person had complex health and physical needs. Their plan gave detailed guidance about how to support this person. It included tasks which the person wanted to complete themselves, or to be involved in and how to do this.

The service was reviewing people's care needs face to face every six months. People were asked for their views on the service they received. We could see from looking at people's assessments that they had been asked about their interests, hobbies, and what was important to them. People had been asked what they wanted to be called and how they wanted staff to treat them. However, we noted that people's assessments did not include information about people's past achievements, and experiences.

The staff we spoke with said they did spend time chatting to people during tasks. These members of staff told us how important this was to the people they supported and how they made time to do this. People confirmed to us that staff did engage with them chatting. One person said, "They [staff] might have a few minutes at the end but we talk as we go along." One relative said, "Most of them (staff do chat) but it is difficult when they are short on time."

Where the service was commissioned to provide social support to people, they told us that they chose what social activities they wanted to do. One person said, "They take me where I want, like shopping." We spoke with a member of staff who told us how they were supporting a person to get out more to hopefully lift their mood.

Requires Improvement

Is the service well-led?

Our findings

During our inspection of NR Care we found issues with the management and leadership of the service. There were gaps in processes for monitoring the quality and safety of the service. The processes they were operating failed to identify the shortfalls that we found at this inspection.

We were shown a collection of questionnaires which the service had sent to people who used the service and their relatives last year and this year. Looking at the 2016 questionnaires we could see that when people had raised issues, where possible, they were contacted and action was taken to address the issues raised. The 2017 questionnaires had been analysed and statistics had been produced. In some areas it stated that 8 per cent were "dissatisfied." We asked the nominated individual what the plans were to address this. We were told that there was not a plan at present. We looked through a sample of the, 'dissatisfied' questionnaires. These people had chosen to be anonymous so it was potentially challenging for the service to address their issues directly with them. The nominated individual said they would change the wording on the questionnaires to encourage people to share this information. However, this had not been considered before and no action plan was in place to respond to these issues.

The service supported a large amount of people but they had no system to effectively monitor late and missed calls. The nominated individual and acting manager told us about the electronic system they used to monitor care visits. An on call member of staff was informed if a visit was late or had been missed. This relied on this member of staff to then take action when they received an alert. However, they had no system to monitor trends or patterns and to address late or missed care visits. We were told about a person who had recently called the office to say they had had some missed calls. Action was taken to address this, but this relied on the person calling the office in the first place. There current system had not identified this issue. The service supported some people who might not know if a visit was late or missed.

There were insufficient systems in place to monitor the quality of care and to address shortfalls in staff performance or conduct effectively. The previous manager and office staff co-ordinating care did not always have a focus or understanding of what a quality service looked like. This was in terms of responding to concerns relating to staff practice. We found and were told about five recent examples when potential issues were identified relating to the quality of care people received. These were either not addressed or addressed in a meaningful way. Staff practice was not monitored, people were not spoken with. There was also no investigation to address these issues. Instead individual members of staff were 'taken off' that person's care visits. The acting manager referred to these situations as, "Character clashes." However, when we and the nominated individual looked at these situations, concerns of staff practice were identified. As no investigation had taken place the nominated individual could not be confident that other people who used the service had or could experience the same issues.

We discovered a potential safeguarding event which had not been investigated. When people raised complaints and concerns these were not investigated or they were not investigated in a robust way. There were no systems in place to guide staff practice when issues and concerns were found. People's care

assessments did not fully explore the risks which people faced and then create the appropriate plan to try and minimise these risks. Robust plans were therefore not always produced to guide staff about how they should be monitoring a potential risk and then how they should respond when risks develop.

Staff were not receiving regular and frequent competency checks. An issue had been raised about one member of staff's competency. They received a face to face supervision but no competency checks took place, to see the issues were continuing or if this member of staff needed additional support. People raised concerns about staff practices and these were not checked after these concerns were raised.

Auditing processes were either not effective or they were not taking place. We had identified issues by auditing a sample of care assessments, reviews, and daily notes. Had the service been auditing these records, they could have discovered these issues. When we looked at a sample of people's daily notes and reviews they stated an audit had taken place. We found issues in two people's daily notes and in people's reviews, where these were listed as having been audited. There was no evidence either as part of the review or from these audits that action had been taken to address the issues that had been found. For example a person's needs were changing, a person was potentially not eating regularly, and staff had possibly breached people's confidentiality.

The service's PIR report they sent us stated that people's records were being audited on a regular basis. However, we found this was not the case, or they were not robust enough.

The service was auditing two or sometimes three people's MAR charts a month. However, the service supported a large number of people. When we looked at some of the MAR charts which had been audited, we saw that issues were identified, but there was no evidence recorded about what action was taken to address these issues. We also noted that in all cases some months had passed until these MARs were audited, this meant that the issues found, were likely to have continued, when they could have been prevented from doing so. There was no system in place to check if people's MARs were being regularly monitored and audited. One person's MAR had not been checked since December 2016.

The provider was not completing regular audits to monitor the work undertaken of the registered manager when they were working at the service. The nominated individual felt a lot of the issues we found were attributed to the poor practice of the previous manager. However, they were not monitoring their work and they had not created systems to prompt staff about what actions they should take to focus staff on providing a quality service. The new manager and nominated individual were not aware of the issues we found until we brought them to their attention.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual knew about the important events they must notify us about by law. However, the CQC were not notified about the potential safeguarding concern when this was brought to the attention of the previous manager.

The above concerns constituted a breach of Regulation 18, the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

We asked people and their relatives if they had confidence in the service. One person said, "From what I know of it yes, if you have any problems you can ring them and they sort it." One person's relative told us, "Yes I think it is on the whole because if I ring up about anything they are very helpful." Another relative also

told us, "Yes because they look after my [relative]."

People told us that they received care when they wanted to and by a regular group of staff. They found the office staff approachable and helpful. All the people we spoke with said they would recommend the service to others.

The nominated individual had organised a coffee morning recently inviting people who used the service and their relatives. The aim of this was to encourage a network and relationships to develop amongst the people who used the service. This was also to enable office staff to meet the people, who the service was supporting. The nominated individual said they were going to make further plans to do something similar in the future.

We were told by the nominated individual about a new role the service will be providing. This is a co-ordinator whose specific responsibility will be to build better links with people and the service itself.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) and (2) (a). Care Quality Commission (Registration) Regulations 2009 (Part 4): 18 Notification of other incidents. The registered manager had failed to notify the commission about important events which they must notify us by law. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (RA) Regulations 2014: Need for consent The provider had failed to ensure that people always consented for the care and treatment provided. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment

	The provider had failed to ensure that people were always protected against improper treatment. Regulation 13 (1) and (2) and (3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA 2008 (RA) Regulations 2014: Receiving and acting on complaints The provider of the service did not respond to complaints in an effective way. 16 (1) and (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider of the service did not have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 17 (1) and (2) (a) (b) (c) and (e).