APT Care Limited

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Inspection report

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17 December 2018

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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?	**Inadequate**

Summary of findings

Overall summary

APT Luton Ltd is a domiciliary care agency that provides personal care at home for people being discharged from hospital on short term care packages for between 10 and 42 days. APT Luton Ltd also provides personal care for people receiving end of life care at home as well as people on long term care packages. At the time of the inspection 134 people were receiving care by the service.

This inspection took place between 31 October 2018 and 13 November 2018, and was announced. This was a planned inspection based on the rating at the last inspection. The rating at the last inspection on 30 October 2017 was requires improvement. This is the fourth consecutive time the service has been rated requires improvement.

We carried out a follow up visit on the 17 December 2018 to get more information to support our judgement. We saw that many changes had taken place and improvements had been made in the areas we were particularly concerned about in November 2018.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During the last inspection people raised concerns around staff's levels of spoken English being poor, complaints and missed visits. During this inspection we saw some areas where improvements had been made since our last inspection and others where it had not. The impact of this in relation to the risk of harm and poor governance has meant the rating remained requires improvement. The service has been rated overall requires improvement for the fourth consecutive time.

The registered manager ensured the rotas had enough staff on duty and the deputy manager has introduced a system of checking visits manually each day. As a result, people told us the concerns around missed visits had improved. However, from records on daily notes and what people told us, visit times were still being cut short meaning some people felt rushed. Concerns around how complaints were managed has greatly improved and there are now systems in place to effectively manage these.

Other concerns around staff using mobile phones on shift, staff`s poor levels of spoken English and staff speaking to each other in their own languages while supporting people who did not understand those languages had not improved. Some effort by the provider to resolve these concerns had taken place. People told us that this often left them frustrated and concerned that staff did not understand what they said.

We discussed our observations with the provider who was keen to improve the quality of care people received. The provider has informed us since our visit, they were working with a local education centre to provide staff with language support where needed.

During the follow-up visit, we found that action had been taken by the provider to discuss the concerns around language and use of mobile phones with staff. In time this should reduce the concerns that people had.

Overall, people told us they felt safe and were very happy with the care provided except for the areas of communication and short visits. However, we found that staff knowledge and current systems and processes for assessing risk, staff training and medicines meant that people were not always safe from the risk of harm and abuse.

People told us they felt well cared for by staff who knew them well. However, people had concerns over some staff not being able to communicate clearly and unfamiliar staff who did not know how to meet their needs such as how to use hoists.

People had good health care support from external professionals to manage people's nutrition and clinical care.

Staff training was not always effective meaning staff were not always suitably skilled and competent to safely meet people's needs. We recommend that the service finds out more about training for staff, based on current best practice, in relation to specialist areas of care provided and competency checks for staff on practical application of learning.

During this inspection, we found concerns around management of medicines, safe and effective risk management and staff competence, skills and knowledge. We recommend that the service seek advice and guidance from a reputable source, about safe management of medicines, personalised care planning and assessing risk.

On our follow-up visit, we found improvements in how medicines were managed. We found that although overall the risk had reduced, there were still some concerns around timings and clarity of instructions which could lead to mistakes being made. We discussed this with the provider who will take r action to improve this.

We found that in staff member's files that we reviewed, one staff record did not show that a Disclosure and Barring Service (DBS) check had been completed. In four staff files that we reviewed out of 6 files there were gaps in employment history which had not been followed up. These are all important checks for the registered manager of the service to be confident that people are safe in the company of the care staff.

During our follow-up visit, the provider showed us evidence that the missing DBS had been completed. We still had concerns that employment history was not followed up. Also in three staff files, we found staff had been shadowing more experienced staff in people's homes prior to their full DBS check. We also found that one staff had a DBS from a previous employer, but not from APT Care Ltd. This raised concerns around the safety of people. We discussed our concerns with the provider and they will be checking each file and promised to ensure that this practice did not happen again.

The care records we viewed did hold basic information about people's needs but were not personalised, sometimes difficult to read and information not consistently recorded. Audits were not always correct and some did not mention outcomes and actions taken.

All staff and management told us that it was their desire to give a good quality of care and for the best interests of people to be maintained. However, the registered manager did not show an understanding of

their role in engaging with and managing people and systems to ensure safe and effective running of the service.

Quality assurance systems and processes were not operating effectively. It is important that all records, systems and audits enable the registered manager to clearly identify and manage risks and concerns. The registered manager must have full knowledge of all issues, actions and outcomes. We recommend that the service seek support and training, for the management team, about leadership and quality assurance systems and processes.

During the follow-up visit, we found that improvements had been made to quality assurance systems. However, we found the registered manager was not the person responsible for the implementation of these changes. Therefore, while the changes were positive, we still had concerns around the lack of oversight and governance.

The provider is legally required to notify the CQC and share relevant information about risks and incidents that have occurred while supporting people with personal care. We found the CQC were not notified of safeguarding incidents that had occurred.

Since the inspection in November we have found that the service is now notifying the CQC of incidents that occurred.

More information is in detailed findings below

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

We will meet with the provider following this report being published to discuss how they will make changes to ensure the provider improves the rating of the service to at least good. We will revisit the service in the future to check if improvements have been made.

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 told us they felt safe and were generally happy with the quality of care provided.

Systems for managing medicines did not ensure that people were safe from risk of harm.

Care plans and risk assessments did not always identify all risks and did not offer sufficient guidance for staff on how to safely manage people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the skills and competence to safely carry out their roles and responsibilities.

Assessments of people's needs were carried out but were not effective in identifying all needs and changes in care needs were not always identified and documented.

People had mixed views on whether staff had the skills to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Most people told us that staff were kind and caring.

People felt that staff treated them with respect.

Staff using their mobile phones during visit times was not caring.

We received mixed views about the care being provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were being well managed and there was a complaints policy in place.

Care plans did not provide person centred information about the people using the service.

People struggled to communicate with staff due to poor levels of spoken English.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems required further improvement to ensure they appropriately identified the concerns found during this inspection.

Spot checks and observations of staff were undertaken, however did not cover several key areas in enough detail such as medication and moving and handling.

The staff we spoke with told us they enjoyed working at the service and were supported by the management team.

APT Care Limited

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 give a rating for the service under the Care Act 2014.

This first part of the inspection took place between 31 October 2018 and 13 November 2018, and was announced. We gave the service 24 hours' notice of the inspection process because they provide a domiciliary care service and we needed to be sure that they would be available and people could be notified. The site visit was carried out by two inspectors who visited the service's office on the 5 November 2018.

On the first day of the inspection process, one expert by experience conducted phone calls to people receiving care from the service and their family members. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the third, fourth, fifth, and sixth day of the inspection process one inspector conducted phone calls to people receiving care from the service, their family members and staff.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications which the provider had submitted to us. Statutory notifications contain information about important incidents and events which take place at the service, such as safeguarding alerts and the provider information return (PIR) which providers are legally required to send to us and gives us updates on things the service are doing to improve. We also spoke to the local authority and reviewed the local authority contract monitoring report of the service.

During the inspection we spoke with nine people who received care from the service, as well as four of their relatives. We also spoke with six members of care staff and three members of office staff. In addition, we spoke with the deputy manager, the registered manager and the director.

We reviewed the care and support plans for seven people to see if they were accurate and up-to-date. We looked at a range of other records in relation to the management and running of the service, including six

staff recruitment files, training, supervision records and quality assurance and monitoring procedures.

In order to get more information to support our judgement, we carried out a further visit to the service on 17 December 2018. This was unannounced. During this follow-up visit, we checked whether the provider had put systems in place to improve areas we were particularly concerned about following the earlier visit. We looked at three care records, eight staff records, incident and accident reports, medicine records, and quality assurance records. We spoke with the registered manager, the provider and the deputy manager. We also spoke with three office staff who completed various quality monitoring checks.

Requires Improvement

Is the service safe?

Our findings

Aspects of safety were not consistent enough to protect people from the risk of avoidable harm.

People's views on feeling safe varied. For example, people told us, "I do feel safe, because without my four visits a day, I would not be able to continue living here on my own" and "I feel safe but I do not like new staff that I do not know. I have been getting a lot of new staff lately and I do not know why…I am very frightened when using the hoist, yesterday I didn't get out [from bed] as they sent two new staff together who I did not know."

One relative told us, "We did have an issue when someone did not know how to use a hoist and I had to help and show them how to do it. I did report to the office and now they send regular carers." This meant that people were exposed at risk of harm because staff were not knowledgeable in how to move them safely.

Staff understanding of how to reduce the risk of avoidable harm varied. When we asked staff how they kept people safe they told us it was about the environment. This meant that staff did not always have adequate knowledge of how to ensure people were safe.

Some people used oxygen at home. The provider confirmed they had not completed a risk assessment around this as staff were not directly dealing with the oxygen. Staff responsible for assessments confirmed that they were not aware if other agencies involved in people`s care had assessed this area. This meant that some staff were working around oxygen tanks without any precaution or knowledge of how to safeguard people and themselves.

Records used to check risks such as moving and handling, hydration, nutrition and pressure care were inconsistent, sometimes illegible and not used to understand progress or risk. For example, they did not mention the size of the sling to be used and were not detailing the process of how staff were to assist people who needed the hoist. One risk assessment for a person who needed support to move in bed detailed that staff should support them to move in bed. However, it did not explain how to safely do this or what equipment might be needed. The care plan simply said, 'Carers to support and supervise.'

Risk assessment tools to assess the level of risk to people who develop pressure ulcers (Waterlow) and the risk of malnutrition were not used. Turning charts were not in place for people who could not move in bed independently. This meant that risks to people`s health were not assessed, known or appropriately managed by staff.

However, during a follow-up visit we found that the systems for care planning and assessing risks had improved. New care plans had been introduced for people newly using the service. The provider had planned for one staff member to begin the process of reviewing and updating all care plans onto the new format.

The provider has also introduced a new one-page profile for all people newly using the service to enable

staff to have important information about care needs immediately. These new systems meant that staff now had information necessary for them to provide safe care.

Some people managed their own medicines or were supported by their relatives to do so. Medicines were stored in people's own homes. Where care staff handled medicines, records showed the management of medicines needed to improve in relation to receipt, correct administration, stock control and balances.

Staff we spoke to did not know the potential reactions of not administering medicines correctly, which could have led to ill-effects for people. The director told us that not all of the pharmacies produced the patient information leaflets. The provider did not specify methods of administration and main side effects or contraindications on the persons medicines profiles, which would have given staff guidance in this area. A staff member said staff administering medicines, "Would not be able to recognise if they were administering the correct tablets."

The provider had not used appropriate systems to monitor how people received their medicines and this increased the risk of people not receiving their medicines as intended by the prescriber. Staff told us that in one case a person's medicines had gone unsigned for nearly a two-week period. Staff told us the persons relative always made sure medicines missed by staff were given by them so the person would not be harmed. However, this increased the risk for the person to be overdosed in case staff administered their medicines but not signed to indicate they did so.

One person told us, "I do usually get my tablets on time, because I must be one of their first visits every morning." However, one relative told us, "I came in one lunchtime to discover that the carer in the morning had written in my relatives' notes, that they had refused to take their tablets…I then discovered that the carer, having gone to the box and not finding any tablets in it, had ignored the new box sitting right next to it and had decided to write in my relatives notes that they had refused the tablets without telling either the office, or myself. There could have been serious consequences, because one of my relative's pills can't just be left off when someone feels like it."

The Director told us that all staff received medicines training however, this was classroom based and the competency tests were theoretical only.

These concerns around medicines, risk management and staff skills meant that the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During a follow-up visit we saw that systems and processes for managing medicines had improved. There were now safeguards in place so that changes in people's medicines were managed safely. Senior staff now assessed all medicines during the assessment process for people receiving short term care. However, we still had concerns around the timings of medicines, as some people had received medicines inside of the required four-hour gap.

There were also still concerns about there being enough information about medicines, in terms of any contraindications and more specific direction for administering medicines, especially creams. For example, one person's medicine chart showed that they used three creams, but the medicine administration record and care plan did not state where these should be applied. We discussed this with the deputy manager and the provider who accepted the need for more detail and agreed to update the medicine charts and care plans with this information.

The provider did not use agency staff as they had enough staff employed and we saw that all staff went

through a full recruitment process. However, from the staff files that we viewed one person did not have a Disclosure and Barring Service (DBS) check on file and four staff had gaps in their employment history that the registered manager had not sought to clarify. (DBS) checks should be checked prior to commencing employment.

The (DBS) helps employers to recruit suitable staff by checking backgrounds and police records to staff are suitable to work with vulnerable people. This meant there was an increased risk some staff were working without full and proper checks to ensure they were fit to do so.

The failure of the provider to undertake a DBS and follow recruitment requirements meant that the service was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out further checks during our follow-up visit and the provider was able to show us the DBS record that had been previously missing from the staff file. However, there were still a lot of gaps in almost all staff files that we viewed in relation to checking employment history. We also found that at least three staff had been taken out to people's homes to shadow more experienced staff as part of their training and induction prior to the DBS certificate being issued.

We discussed this in depth with the deputy manager and the provider who agreed to check all staff files and ensure that moving forward, all staff have full DBS issued prior to shadowing. The provider also agreed that employment history will be fully explored and recorded at interview stage. These systems ensure that staff are suitable to support people safely.

The provider had ensured enough staff were on shift. The deputy manager told us they used a hand-written checklist to check that each visit had taken place. This method appeared to be effective as people told us that they have not experienced a missed visit in over seven months. This was an improvement since the last inspection.

Records showed us that staff were logging out of visits between five and 15 minutes earlier than the allocated time. Staff told us, "If the visit is 30 minutes management allow us to leave after 24 minutes we can log out and then six minutes is the travel time if you have finished your work."

People told us, "We do not have to pay the bill ourselves, but I have thought that it is a bit off that the carers do not always stay for the full amount of time because I know the council are paying for this for us" and "I don't think they're unkind, it's just that they do so rush me around sometimes." This meant that people were not getting their full visit time.

We spoke with the registered manager who confirmed that staff travel time was included within the time allocated for visits and staff were told that they could leave early to accommodate this if the work was completed. However, the local authority told us that travel time should be planned outside of the contracted visit time, which meant that the provider was likely in breach of their contractual agreement with the funding authorities.

The majority of staff we spoke to had a very basic understanding of supporting people to remain safe from harm and abuse. Staff had received training in this area by the provider and most were able to give a few scenarios of situations they would report but struggled to tell us about the different forms of abuse and signs and symptoms to look out for. This meant that there was a risk that staff were not able to recognise some forms of abuse and people were not safe from the risk of harm.

The service managed the control and prevention of infection. Staff followed good infection control practices and used personal protective equipment (PPE) to help prevent the spread of healthcare related infections. Staff told us, "I wear gloves and then as soon as I am finished I will wash my hands and put new gloves on again and for showers I put on my apron."

We discussed with people what lessons learnt meant, such as sharing outcomes of incidents or complaints when they occur and asked if lessons learnt were shared with them. People told us, "I cannot recall ever hearing anything."

Evidence was available to show that when something had gone wrong the office team responded appropriately and used any incidents as an internal learning opportunity for the service improvement plan.

Most care staff spoken to either did not understand what lessons learnt meant or thought that it was only about when they had made a mistake. We explained to staff what lessons learnt meant such as, learning from recent incidents both internal and external to the company. The aim is to then avoid the risk of incidents reoccurring or reflecting on good practice to promote positive care. When prompted a second time, staff said, "I speak to the office and inform them."

The provider confirmed that they did review risk assessments and care plans following incidents.

During our follow-up inspection we saw evidence that the provider had now put in place meetings between senior staff and care staff to ensure that information was shared more effectively.

Requires Improvement

Is the service effective?

Our findings

Assessments of people's needs were in place and each person before they started using the service had a face to face assessment at home by senior care staff to discuss what they needed and their preferences.

Expected outcomes were in care plans but people told us care and support was not always regularly reviewed. For example, people said, "Yes, someone from the office visited a couple of months ago to go through the care plan and to make sure that I was happy with everything" and "I don't think I remember having anyone visit from the office to talk to me about my care since I started with them well over a year ago now."

Records showed us that care plans were not personalised or detailed enough to enable staff to give a good standard of care. However, people told us that staff would be flexible and do extra jobs when asked. This meant that the quality of care was dependent on the initiative and skills of individual staff and people`s changing needs may not have been recorded on care plans or assessed.

Every care plan had a generic section to remind staff not to leave things on top of pressure mattresses. However, other sections of one care plan viewed stated no pressure equipment was used. This information was confusing.

People told us, "They appear to have all the skills to look after me. It is perhaps just the verbal English skills they could do with sharpening up a little." This has been an ongoing concern raised in previous inspections. A relative told us, "I have asked their carers, how would they like it if somebody was talking in a different language that they could not understand. All I seem to get is a shrug of the shoulder and they just carry on, sadly."

The director told us they were putting staff through English language tests when newly employed and working with local education centres to offer support for English classes to try and address this issue.

Staff told us they completed a four day induction with in house training and had the opportunity to shadow and to be shadowed by a more experienced staff member when they first started working.

The local authority gave training for staff from external qualified health professionals for all clinical needs such as supporting people who used PEG feeding systems and pressure care. PEG (percutaneous endoscopic gastrostomy) is a surgical procedure where a feeding tube is inserted in the stomach to feed people who cannot swallow. All other training was provided by the director and other senior staff who had attended train the trainer courses.

The director gave staff competency workbooks for staff to document their knowledge following training but these were not available to be viewed and no record was kept by the provider. We saw competency checks on medicines and these were theoretical only, the competency tests did not assess staff`s practical skills and ability to administer medicines safely.

During a follow-up visit, we saw that there were new scenario based competency checks used with staff as part of the medicines training. We discussed these with the provider and the benefit of also including assessments of practical competency. The provider agreed to consider the methods used to ensure staff are fully competent and confident to administer medicines and to identify and report errors.

The service had a supervision matrix in place to plan staff`s supervision. Most staff told us they did have the opportunity for supervision and appraisal but said this was not consistent. Staff told us the frequency varied between some staff having received supervision every six weeks, some staff every three months, others only once or twice in a year and one staff told us none at all. This matched records that we viewed.

Staff told us that the quality varied too, some staff said that they could speak up during supervision while other staff said they were asked a list of questions to answer. This meant that support and development opportunities for staff was not consistent.

Where people were at risk of poor nutrition and dehydration staff were asked by management to ensure that they offered plenty of fluids and food and the daily notes had a section for staff to confirm if they gave people access to fluids.

One person told us, "I have lots of things I can choose from, both in the fridge and the freezer and the carer never mind's cooking whatever it is I fancy eating." Another person told us, "They insist on making me drinks, when they arrive, during the call and last thing before they leave" and "I have four bottles of water here by my side and when the carers come in I usually get through about three bottles a day and the carers that come will make sure that I have them topped up and get enough."

Where people needed their food to be prepared differently because of medical need this was catered for by staff and documented in care plans but relevant health assessments and guidelines were not in place in people's files.

Where people needed support from external healthcare professionals this was arranged and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as hospitals.

Staff liaised with local general practitioner services on behalf of people. One staff told us, "I could get prescriptions and speak with the doctor. I explain to health professionals what is my opinion and although I have had medicines training I explain that I am not a qualified professional."

We were told by the provider that staff received first aid training but when we spoke to staff their knowledge of first aid was limited and records showed that only a few staff members completed the training.

Staff told us they would contact emergency services if concerned and contact the office for support if people's healthcare needs changed. This meant that people were at risk of harm because staff were not trained to act quickly for example, in the case of choking, burns and falls.

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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty (DoLS) were being met. At the time of the inspection none of the people using the service required an application to the court of protection for DoLS. However, the provider did have a policy in place detailing the process should this be needed.

People told us, "I have a choice as to whether I feel like having a shower every morning, and if I do not, then the carer will just help me with a strip wash instead" and "I can choose when my bed gets stripped and when I change my clothes."

Staff were provided with training on the MCA by the provider however, staff ability to show adequate knowledge of the requirements of their role varied. For example, when asked about supporting people with decision making some staff were able to talk about the process of assessing if a person had capacity and other staff thought DoLS applied to people who had capacity but who only used one or two words at a time to communicate.

This meant that people's ability to make their own decisions was at risk of being incorrectly assessed which put people at risk of not being listened to and not having their rights respected.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and were positive about the staff's caring attitude. People said, "The two carers who I mainly see are lovely and nothing is too much trouble" and "My carer will warm my towel up for me while I have my shower, so I don't get cold, especially on these cold winter mornings."

However, one relative said, "I don't like the fact that they'll [staff] leave my relative eating their breakfast and disappear into the other room where I can hear them on their phone rather than spending time talking to my relative."

People told us staff did not always know their preferences but were happy to do extra jobs to meet changing needs. This meant the care given was not always in line with what has been assessed and agreed in the care plans.

An on-going concern almost every person we spoke to told us about, was the difficulty in understanding staff and being understood due to staff`s poor spoken English. Also, staff talking to each other in languages people could not understand. This was very upsetting for people who told us they felt awkward and distressed as a result. This meant most people we spoke to were left at risk of their needs not being responded to appropriately because staff had limited communication skills.

For example, comments people made included, "I have spoken to the office about the fact that the carers will very often talk to each other while they stand in front of me in their own language. I just think it is so rude because I have not got any idea what they are saying. I'm sure they're not, but they could be saying something quite nasty about me and I would not have a clue" and "Because I have two carers all the time, they will insist on talking to each other in a language I just do not understand. It really frustrates me because they could be saying anything about me which isn't very nice."

Staff also acknowledged these difficulties telling us, "It is easier face to face but sometimes I struggle. I try to understand, I understand them [people] talking, I understand more than I can speak. Reading and writing is ok. I can read a care plan and write a care note."

During a follow-up visit the provider explained to us new practices that had been applied to ensure that staff working together did not speak a language the person they were supporting did not understand. They said this method of working should reduce the concerns and improve the experiences of people using the service.

We also saw evidence in staff files of an English language test at the interview stage of employment to assess that staff have the basic language skills needed to communicate effectively with people, and to report and record the required information. This should help to safeguard people from unsafe care, and improve communication and relationships.

The ability of staff to speak in languages other than English was for some people a benefit that meant they

could easily converse with care staff in their native language. This meant that people with diverse language needs had their needs met.

Staff spoken with showed genuine concern for people and were keen to ensure people's rights were upheld and that they were not discriminated against in any way. This meant that people's right to privacy was respected and people were given choice and control in their day to day lives.

Requires Improvement

Is the service responsive?

Our findings

Staff did not always know people's likes, dislikes, and preferences however they did all ask about them on arrival and people told us staff always checked with them what they wanted. Relatives were involved in people`s care where they chose to be and where people wanted that.

People's needs from assessments were recorded although this was very basic and showed no follow through. For example, care plans viewed recorded needs such as "no longer uses a hairdresser" and "needs support to move up the bed" but no explanation of what options were considered or used to keep a person`s hair maintained or how to support them to move in bed.

Care was not always responsive to people`s needs. For example, daily notes for one person who used a catheter showed that their continence pad had not been changed from 9am one day until 6.30pm the following day because it "was still dry." The notes did not record whether the person had received a wash or whether staff had sought advice about the persons lack of bowel continence during this period.

People and their relatives did not know who the registered manager was and if they had ever spoken with them. However, they knew how to make complaints to the office staff if they needed to but the comments were mixed on whether this was acted on and they told us feedback on outcomes were not always given to them.

For example, one person said, "I have spoken about the carers knowledge of English. Some are much better than others, they're certainly not of a consistent standard. Very little has changed" and "I did complain about the number of missed visits and that has definitely resolved itself, touch wood!"

Most people we spoke to told us that responsiveness to complaints had improved over the last year and overall were much happier with how they were being addressed. The service made calls to 15 people each week to check people`s experience of the service. The content and outcome of the calls were recorded and action taken by the quality assurance team to discuss any concerns.

People who needed it were supported with end of life care. However, the records in place showed no additional support needs or record of wishes for end of life and serious illness were documented. Staff told us that due to the nature of the service, they were receiving people from hospital discharge with very short notice and were often supporting people on end of life care packages with little to no information about that person's needs, risks, or diagnosis.

Staff explained, "Care plans are not in place when we first go, the hospital assessment goes to the office and is then emailed over and in the end, management book the person in for assessment and staff get a copy in the persons folder. The care plans are very template like with brief information. There used to be more information but now it is just not personal. Staff do not even know what the person is dying from."

The local authority confirmed that the provider had recently identified the quality of information received on

initial assessments from hospitals was a concern and this was being discussed in conjunction with the local authority to make improvements.

Staff told us that they share information informally about care needs amongst themselves for people who are new to the service so that staff are aware of what the person or their relative has asked for until the formal care plan is written up. This meant that information about risks and needs that care staff collated were not being recorded formally and therefore at risk of being lost.

The new one-page profiles that had now been introduced at the time of our follow-up visit should enable staff to safely meet people's needs in the first 24 hours of care. This profile shows all important information required to provide safe care before a full assessment is completed and care plans are in place.

Records showed that very few staff had received training in end of life care. However, staff respected people's religious beliefs and preferences and did follow what people and relatives asked them to do.

Staff supported people's relatives before and after a person died. Staff told us, "I spoke to the family, usually it's the family you will get your information from. You can get quite close to the families and get asked if you can attend funerals and things."

The service showed compliments from relatives thanking staff for their care and treatment for people nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

The service was not well-led.

There were on-going concerns prior to the last inspection such as complaints about staff using their mobile phones and speaking in languages other than that of the person being supported. These were being discussed via staff newsletters and meetings but further action not yet been taken for staff who continued with these practices. This meant people were still experiencing difficulties they told us about in relation to having their needs and wishes understood.

During our inspection we noted a number or areas for development such as, record keeping, failure to notify CQC of safeguarding concerns, staff skills gaps and knowledge. These were not identified and acted upon by the providers own audit processes.

The provider had systems in place to check and act on safeguarding incidents which the office staff had reported to the local authority. Since the new monitoring system implemented by the quality assurance staff to manage complaints had begun we had been made aware of a total of nine potential safeguarding incidents. These incidents had been forwarded to the local authority and action and outcomes recorded.

However, while the CQC were informed of some of these by other sources the provider had failed to send in a statutory notification for any of these incidents. It is a legal requirement to notify the CQC of serious incidents that indicate risk or potential risk of harm and abuse to people being provided with care.

An example of the types of incidents and concerns that were not reported include, pressure care, bed rails, medication and complaints and allegations of poor practices. This meant that we were not aware of some incidents that had occurred at the service. Failure to notify the CQC of serious incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We have found that since the inspection on 05 November 2018 the provider has begun to notify the CQC about incidents that had occurred.

The registered manager had no effective monitoring and oversight of the overall quality assurance systems. This was identified in the previous inspection but no improvement had taken place. The service was not well-managed which led to inconsistency around the standard of work being done by office staff.

Records viewed were very much task led and were not personalised. Following the inspection, the provider sent us a new format of care plan which they planned to implement to be more person centred and to give more detailed information about people's needs.

Care note audits were not correctly completed when we cross referenced them against daily note records. For example, the audit showed that all tasks in care notes had been completed but we found there were a number of gaps on care notes that had not been identified in the audit.

Where errors were found during medicine audits nothing was recorded about action taken with staff and the outcomes of the errors in terms of impact to people. We found no evidence that anyone was harmed because of this due to the intervention of relatives however, the lack of identification of errors left people at potential risk. Poor records and processes increased the risk of harm to people.

During our follow-up visit, the provider showed us evidence that they had trained the staff responsible for medication audits how to do this more effectively. The provider gave instruction to staff on what information needed to be recorded to show what actions had been taken, including outcomes of meetings with care staff.

We also saw that they were starting to discuss poor performance concerns with staff using a more formal process. This would enable them to evidence how they addressed concerns raised by people using the service.

The registered manager demonstrated a desire to provide person-centred, high-quality care but was not able to state how this was going to be achieved other than, "Working hard and improving what we do to give a good quality of care."

Office staff positively encouraged feedback and acted on it to continuously improve the service, for example by involving people in resolving complaints they had made. Office staff were able to produce a service improvement plan when asked which they had developed themselves. However, there was no direct involvement in this process by the registered manager and when asked about improvement plans or business aims in place the manager said, "Nothing in writing but we work very hard."

When asked about the vision for the service, the registered manager said, "I hope to have a good rating, to employ good staff, and improve. To have more training, this is the time of the service user and it is their time and we are there to provide quality care." The registered manager was not able to say how they aimed to achieve this or talk about any current objectives they were working on.

When asked what the values for the service were the registered manager said, "Values are to provide again, it is really important for me to provide a good service, when I am not having good feedback it is not nice and we are working hard to provide a good service."

Staff were unaware of what the service vision and values were, saying, "In my vision, if the company is good they are flexible and we can manage our family and do our work as well. When we need anything they help us, always someone there to get advice." This meant that there was not a clear vision or set of values for the service that was shared and known by staff.

Quality assurance systems and processes were not operating effectively which meant the provider is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider held meetings and we viewed some of the minutes of those meetings. Management meeting minutes dated 31 October 2018 were handwritten and very difficult to read. This meant that staff not able to attend the meeting would struggle to know the content based on the minutes.

Other typed minutes stated staff should put bed rails up as a standard feature and show sensitivity and dignity for people receiving end of life care.

Staff meeting minutes from 3 May 2018 talked about supporting staff to follow their religious beliefs and that

flexible working was agreed which included the agreement that staff could be late when visiting people. The minutes did not detail how this decision was made and what consultation had taken place with people receiving the service and the potential impact of delayed visits.

Minutes viewed were instructional and did not seek the input of the wider staff team nor state clear actions and outcomes with follow up. When asked if they attend and can contribute to staff meetings, one staff told us, "No" and another staff said, "Yes definitely, once a year maybe twice."

The registered manager told us they have recently asked senior staff to hold meetings with local care teams every two weeks starting from September 2018. Minutes of these meetings were not available and staff spoken to were unaware of them.

Not all the staff understood their roles and responsibilities and staff who did understand their roles did so due to their own experience and colleague support. People told us, "They would perhaps be more motivated if they did not concentrate on their mobile phones so much."

The deputy manager was very knowledgeable about the service, processes and the needs of people and staff. The registered manager did not have the same level of knowledge and when asked questions about the running of the service often referred us to the staff member who was delegated that area of responsibility.

The service did involve people and their relatives in day to day discussions about their care but this was not consistent. People, relatives and visiting professionals had completed an annual survey of their views but feedback had not been used to ensure continued improvements were made to the service. The director informed us, "Managers could not act on anonymous concerns as they did not have contact details but had called people who had given their names and contact telephone numbers."

People we spoke to had not had any involvement in developing the services practices and policies other than the annual survey. People told us, "I have been asked my opinion about how I find things when I've filled in a survey in the past, but as far as I can remember that was probably back in the spring. I do not think anybody has asked me since" and "I can't remember anything."

The staff were not engaged to develop the service and told us, "Not up to me to tell my company how to improve" another staff said, "I do not know actually." Both the registered manager and the director agreed this was an area that was not currently utilised and they would consider ways of engaging with people and staff in regard of the future running of the service.

Staff spoke highly of the registered manager and the office team and felt comfortable to speak up if they had a concern. Staff said, "I think it is a beautiful company. They can improve the service by training us. At the moment I am working and learn from my experience with the patients."

We saw three newsletters for staff from 2018 which introduced an office staff member each time and covered areas around use of mobile phones, pressure care and inspections. The registered manager told us that staff were given these to read and share with the people receiving the service, however, only two of the people spoken to could recall seeing one.

The registered manager acknowledged they needed to personally speak with people more and ensure that people using the service and their relatives knew who they were.

During our follow-up visit the registered manager told us that they have been regularly visiting people in their homes and completing care visits with staff to get to know people. They explained that people had responded positively to this.

The service had useful links with local organisations such as the hospitals and the local authority and regularly attended provider forums.

The registered manager and staff teams were all very keen to improve and develop the service and have an open culture of wanting to give skilled care. The registered manager needed to be clear about what improvements were needed and how they would be achieved.

During our follow-up visit, we found that there had been many improvements made and plans to make even more changes. While we saw that these changes were very positive and the service was moving in the right direction, the changes had in the main, been implemented by the deputy manager, quality assurance staff and the provider. The registered manager's role in these changes was unclear.

Additionally, some of these plans were not yet fully implemented. For this reason, we still had concerns about the registered manager's effectiveness in having oversight of the service, their knowledge of the regulations and whether they had the skills that would ensure improvements could be made, sustained and embedded into the practices of staff. This is a fourth consecutive inspection when the service had failed to achieve an overall rating of 'good' and we will use our regulatory powers to ensure that quick and sustained improvements are made. This is necessary to safeguard people from potentially unsafe care.