Horizonz Care Ltd

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Inspection report

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Date of inspection visit:
20 July 2017

Date of publication:
20 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Horizonz Care on 20 July 2017 and it was an announced inspection.

Horizonz Care is a domiciliary care agency that provides personal care for people living with dementia, mental health needs, physical, sensorial and learning disabilities in their own homes. At the time of this inspection they were supporting 25 people.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection the service was rated required improvement and had two breaches of regulation related to safe care and treatment and good governance. At the last inspection on 08 August 2016, we asked the provider to take action to make improvements to their processes in relation to supporting people with medication and good governance. At this inspection we found that the service had made improvements and was no longer in breach of regulation for safe care and treatment in good governance. However, we found the service was breaching regulations concerning safe recruitment and consent.

People who used the service were protected from the risk of harm and abuse. There were policies in place in relation to safeguarding and whistleblowing procedures. Care workers understood these policies.

People's risks had been assessed and there were plans in place to minimise and manage those risks.

New employees were checked before they could work with people but this practice was not always consistent.

People told us that care workers turned up on time to provide care and there were enough care workers to support people.

People's medicines were not always managed safely. People and their relatives told us that medication was given on time and not missed. There were no protocols for 'as and when' required medication or creams. We found that staff's competencies and medication audits were not robust.

Care workers completed an induction to ensure they were aware of their roles and duties. They were provided with regular supervisions to assess and monitor their performance and wellbeing.

People told us they were treated with respect and dignity. They said they were always given a choice and care workers respected their decision.

People's support needs were assessed prior to receiving support from the service. Care plans were detailed and personalised to people's care needs and preferences.

People are supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

The registered manager was able to explain their responsibilities under the Mental Capacity Act 2015 however, we found inconsistency in the mental capacity assessments sampled; some were very detailed but others were not decision specific.

People and their relatives told us they thought the service was well managed. We found there were arrangements in place to monitor the quality of the service but these were not all equally robust.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not always managed safely.

Recruitment process was not always robust.

Staff knew how to recognise and report abuse and this helped to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistently implementing the Mental Capacity Act 2005 as they were not undertaking decision specific capacity assessments.

People received the support they needed to eat and drink; people gave positive feedback about their meal experience.

Care staff had received the support and training they needed to provide effective care.

Is the service caring?

Good

The service was caring.

People received consistent care from regular staff. People told us staff were kind and caring.

People had good relationships with those who supported them.

People were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before commencement of service.

People's needs and preferences were described in a care plan and this was reviewed when people's needs changed.

People told us they were confident that concerns would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were quality assurance systems in place however, some areas required development to drive improvements and ensure performance was assessed appropriately.

Staff told us they were supported and morale was good.

The registered manager had systems in place to ensure effective communication.

Horizonz 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.

This inspection took place on 20 July 2017. The provider was given 48 hours' notice because the location provides care to people in their own homes and we needed to be sure that the registered manager would be at the registered office. The inspection team consisted of two adult social care inspectors.

Before the inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident takes place.

We contacted local stakeholders to have their views on the care provided by Horizonz Care. These included local authority's safeguarding team, clinical commission group, fire service and local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not share any concerns with us.

During the inspection we spoke with four people who used the service and five relatives. We spoke with seven staff members, including the registered manager and the deputy manager. We gathered the views of two community professionals. We looked at records in relation to four people's care and five staff records. We looked at other records which related to the management of the service, including policies and procedures, audits and minutes of staff's meetings.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe with the support provided by Horizonz Care. One person said, "Yes, I feel safe, I am satisfied." Another person said, "Yes, no problem at all" and a third person commented, "Yes, I think so, I never felt unsafe." One relative stated, "Yes, very much so." And another relative said, "Yes, I do, I am very pleased."

Last time we inspected, we found some risks were not being identified or managed appropriately. In particular we found that supply cut off points were not recorded in risk assessments. During this inspection, the registered manager told us this had been addressed and the environmental risk assessment of all people that were using the service had this information. We confirmed this was present in the files sampled.

People's care folders had a list of relevant numbers to contact in case of emergency. Numbers included gas emergency, local authority emergency duty team, GP, Horizonz Care mobile 24h and Horizonz Care office. People and relatives we spoke with were aware of this list of contacts. One relative mentioned that, "At one point there were concerns about gas, a carer smelled gas and contacted the gas company; they didn't leave [person], they sorted it out." This meant that people, relatives and staff members could easily access help and support in case of need and reduce the seriousness of a possible emergency.

We found risk assessments in people's files were appropriate, detailed and person centred. These included manual and handling, falls, premises and environment. For example, one person required support with transferring from bed to wheelchair; their risk assessment included detailed manoeuvres care workers had to do to perform safe manual handling and it specified how the equipment (sling) should be used. We spoke with staff about this particular person and they were knowledgeable about how to conduct the transfer and use the equipment. We asked care workers what they would do in an event of a person having a fall. One care worker said, "If [person] had a fall, I wouldn't move [person], I'd make [person] comfortable, ask where if it hurts, then ring an ambulance; I would report to my managers and do an incident report." This was in line with what the deputy manager explained they would expect staff to do. This meant that staff would know what to do in an emergency situation in order to appropriately support people.

There was an on call system and the registered manager or deputy manager were available to support care workers and people, if required. During our visit, the registered manager gave an example of a contact they had received from care workers that morning, at 6:30am, as the person being cared for was unwell. After assessing the situation the registered manager advised medical assistance was needed and the person was taken to hospital. This meant that risks to people's health and care were responded to timely by staff receiving the appropriate support.

During our last inspection, we found some issues in how medication competencies were being assessed by the registered manager and we found some gaps in the medication administration record (MAR) charts inspected. During this inspection, we checked how people's medicines were being managed and we found some improvements had been made since last inspection but there were still areas where practice was not robust as there we not protocols for 'as and when' required medication, staff's medication competencies

were not properly evidenced and medication audits did not cover all necessary areas according with national guidance.

People and relatives' feedback in relation to medication was positive. When asked if medication was given on time and if care workers followed the correct procedure one person responded, "Yes," One relative said, "They follow the right steps and sign before they leave." Other commented, "Yes, it's quite clear; we get the medication delivered every Wednesday, once [person] did not open the door so the carers went to the chemist to collect it."

Medication support plans were very detailed in relation to people's support needs, preferences and included a list of all medication taken, why it was administered and its possible side effects. One person's medication support plan stated '[Person] has limited mobility in [person's] hands and is unable to remove the right medication out of the blister pack. [Person] requires supporting staff to take medication out of the blister pack. [Person] will take tablets independently with water'. Another person's medication support plan identified the support provided by family and care workers, '[Person]'s medication is given by family members. Supporting staff only apply Cavillon cream as and when required'. We saw when creams were applied the support plan had a body map showing where it should be applied. This meant that care workers were supporting people with their medication in line with their needs and preferences.

There were no protocols for 'as and when' required medication which mean there were no clear written directions for when staff should administer this kind of medication, the maximum dosage and frequency recommended. One person had been prescribed with Cavillon cream; their support plan stated the care worker should apply 'if there is a broken sore and put the dressing over it'. We checked this person's MAR and we could see this cream had been frequently applied in May 2017 and always applied in June 2017 but we could not find any record of what was the rationale behind these decisions. We asked the registered manager who told us this person was being daily visited by district nurses who were directing staff in applying the cream. The registered manager said they would make sure any advice given by healthcare professionals was recorded in daily notes and a PRN protocol put in place to clearly guide staff.

We saw evidence staff had their competency to administer medicine assessed annually. However, on review of these checks we could not see they evidenced all the necessary knowledge acquired by staff member. The registered manager explained the competency process had changed since last inspection and care workers' online training was now complemented by the completion of a scenario that included use of a dossete box followed by spot checks done by the registered manager or deputy manager. The spot checks included observing how staff were administering people's medicines, if consent was sought, if the correct medication and dosage had been given to the right person, at the right time. Care workers confirmed spot checks had been done before they were "signed off" to administer medication. However, the medicines competencies did not include assessment of particular prescribed medicines like topical creams or eye drops, what to do if medication is refused or not administered, what to do in case of doing or identifying a medication error.

We asked care workers what they would do in case of medication error; one said "I would inform the manager", another said "I would check the MAR, if I administered at the wrong time I would report it to the manager, get their advice, write it down and maybe ring the pharmacy." This meant there were some areas of good practice but people could always be reassured that were being supported to have their medicines by staff with the right competences. We discussed this with the registered manager who assured us that they would continue to work towards improving this area by consulting the National Institute for Health and Care Excellence (NICE) guidelines in relation to administering people's medicines in the community.

We checked the systems in place to protect people from harm and abuse. We found, the registered manager

and deputy manager were knowledgeable in identifying abuse and they said if a safeguarding concern was raised to them, they would gather information from the care workers, speak with the person allegedly subject to abuse to confirm they were ok, report it to the local safeguarding team and then to report it CQC. We looked at staff's training records and we found training had been completed and was up to date. We spoke with care workers that were able to identify main types of abuse and what to do if they were concerned about abuse or neglect. One care worker said, "I would report to my manager, if manager didn't do anything I would go higher." Another care worker stated, "If I knew about it I would have to report it to my manager and tell what happened, where, and record it in the (care) observations."

There was a whistle blowing policy in place and a whistle blowing box in the office to allow staff to raise their concerns. Most staff we spoke with were aware of this policy. One staff member said, "I would go to the office and talk to them or go high up." Another mentioned, "Yes, I've done it (used the whistle blowing policy) once because I felt a colleague used a manual handling technique that was rough. They (management) acted on my concerns." This meant that people could be assured that care workers and management would act on any concerns of abuse or poor practice.

At our last inspection we found some issues with safe recruitment practices, namely we saw some files did not contain references. At this inspection, we saw staff files were well organised, staff had completed an application form and there were evidences of the interviewing process and respective score. We found some recruitment checks were carried out by the provider to confirm the people's suitability for the role; however, these were not consistent. We saw references were not always being taken in line with the provider's own policy which stated the requirement of 'at least two satisfactory written employer references' before offering a post. For example, one of the file sampled had one employer reference; other had an employer and a character reference on file. We spoke with the registered manager about this and they explained they had made efforts to get those references but did not have a reply.

This meant the necessary recruitment checks to ensure staff suitability to work were not being followed and this constituted a breach Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to fit and proper persons employed.

Disclosure and Barring checks (DBS) were undertaken to check if prospective staff had any criminal offences. The majority of checks were undertaken before individuals started to work for the agency. From the files sample we found one care worker had started their job in September 2015 but the DBS was dated from January 2016. As referred in our last report, having robust pre-employment checks in place reduces the risk of employing staff who are unsuitable to work with vulnerable people. This meant that some progress had been made since the last two inspections however; improvement was still required to ensure robust safe recruitments procedures were being followed.

We checked how the service ensured there were sufficient numbers of staff to keep people safe and meet their needs. People and relatives told us there were no missed calls or late calls. One person said, "No, if they are going to be late, they would let me know, text me or ring." Another commented, "No, sometimes they are late but they phone me to let me know." One relative said, "No, (care worker) is always on time, same carer except when (care worker) needs to be off. They let us know who is coming so we always know." Care workers told us they had enough time to spend with people. One care worker said, "Personally speaking I go to every call and I don't rush, I like to build a rapport, sit down with people, make sure they are comfortable with me." Another care worker said, "Yes, I always make sure that I am on time, if they need any extra I would stay and I wouldn't go if the service user felt unwell." The registered manager confirmed they were using an electronic monitoring system that would alert the office if the care staff did not log in for the call on time. This meant the registered manager was monitoring the time of the visits and would be able to act timely.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives if they felt care workers had the appropriate training and knew them well. One person said, "Yes"; another person stated, "Yes, they know me well by now." One relative said, "Yes, I do"; other commented, "Yes, them seem very professional."

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and whether any applications had been made to the Court of Protection to legally deprive someone of their capacity.

The 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.

When we looked at people's care plans we found inconsistency in relation to how the registered provider conducted their practice in meeting the MCA requirements and mental capacity assessments had not always been completed in line with legislation and good practice.

For example, there was information in one person's care plan stating that due to their diagnosis of dementia they could not consent to be supported with prescribed medicines. However, a mental capacity assessment to consider this person's capacity around medicines had not been completed and we saw review forms agreeing with care in place had been signed by a relative who had lasting power of attorney (LPA) for property and finance and not for health and welfare, which meant they could not lawfully consent to this decision. An LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you are no longer able to or if you no longer want to make your own decisions. LPA's can be registered for property and finance or health and welfare. This meant the registered manager was asking family members to sign consent forms when they did not have the legal authority to do so.

When mental capacity assessments were completed the quality of its content was detailed. For example, they included how people had been involved during their assessment of capacity and why they weren't able to understand some decisions. However, during our checks we also found that mental capacity assessments were not always decision specific, and there were no records of best interest decisions. We also found mental capacity assessments were being completed for people that did not have any impairment of the brain or mental health need.

This evidence demonstrates a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered manager was not using consistently ensuring that consent was sought from people with the legal authority to give it and mental capacity assessments were not always robust.

Staff's understanding of the MCA and it importance to their work was not consistent. The registered

manager and deputy manager were able to describe it clearly, one said, "We always assume capacity, some service users have the ability to make some decisions, others may lack some capacity but can make small decisions." One staff member said, "If they [people] don't have capacity there is a best interest decision." We asked staff how they would know if a person lacked capacity, one care worker said, "By reading the client's file and also by talking with them" and "If they have the capacity I cannot force it on them, but if they refuse I'll inform the manager and the family." One staff member said they did not have any MCA training and when asked what they would you do if a person lacked capacity to make a particular decision the care worker said, "I probably would help the best way I could." We looked at this care worker's records and their MCA training was up to date.

We spoke with the registered manager about our concerns with the service's compliance with the MCA. They said were under the impression the service was required to have a record of mental capacity for every person using the service. They also said they will review this area and make the necessary changes considering the MCA code of practice.

We asked people if staff requested they consent before supporting them and if they felt their rights were being restricted in any way by staff. People told us they were able to make their choices and staff respected them. One person said, "Yes, I can choose." Another person commented, "I find whoever I see very helpful."

We checked if there was support in place for new care workers and if they had a period of induction where they could learn their new role. The registered manager told us all care workers had an induction period which included being given a copy of the employee handbook, completion of training, shadowing and spot checks done by the registered manager to confirm the care worker's competence. The employee handbook included information about employer and employee's responsibilities in relation to environmental risks, food safety, accident reporting, alcohol and drugs misuse, driving at work and lone working. When we looked at staff's files we confirmed the employee book was being signed as given. The Care Certificate was not being completed however; the registered provider had plans in place to implement this. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers should follow in order to provide high quality care.

We spoke with care workers who told us they had had a period of induction where they shadowed more experienced members of the team. One care worker said, "I shadowed for one week; observed most of the calls, was signed off one week later." Another said, "Yes we had (an induction), it was quite good." This meant that new staff were being supported to learn how to deliver safe and effective care appropriate to people's needs.

During this inspection we looked at the registered provider's training matrix which showed staff training was up to date. Training had been provided on subjects such as challenging behaviour, confidentiality, dementia care, depression, diversity and equality, first aid, food hygiene, hand hygiene, health and safety, infection control, mental capacity act, moving and handling, person centred care, record keeping, administration of medication and safeguarding. We saw role specific training was provided to the deputy manager and included assessing needs, communicating effective and supervision and appraisals. When we looked in staff's file we saw certificates of training completed and respective scores. This meant people were being supported by staff with the appropriate skills and knowledge.

The registered manager told us the team's knowledge and skills were refreshed on a regular basis through supervisions, team meetings and by having a different monthly theme that was discussed at team meetings and guided specific monthly activities. For example, June's 2017 theme was hand hygiene, this was discussed at the team meeting, extra gloves and hand sanitiser was available to staff.

We looked at staff's supervision matrix and we saw supervisions and appraisals were regularly done in line with the provider's own policy. We spoke with care workers about their supervisions, one said, "Yes, I have one to one meetings with my manager, we discuss about concerns but if something urgent happens we will talk on the day"; others commented, "We discuss safeguarding, how the service users are, medication, if there is anything that needs to be changed." When we looked at supervision records we could corroborate these meetings were meaningful conversations used to support and develop staff. This meant that staff were trained to perform in their roles and maintain their skills.

We asked people who used the service about their experience when being supported by staff to have their meals. One person said, "Yes they help me with meals, they will take out whatever is in the freezer. I leave it to them." Another said, "They help me at tea time, they bring the meal out and warm it up, what I choose." We spoke with staff who showed good knowledge of food hygiene and preparation. One care worker said, "We can't just serve food, we have to make it look presentable and make sure is cool enough for them to eat it." We also saw evidences that people's care plans included details about their preferences, for example halal meals.

We saw evidence people received the input of external healthcare professionals, for example, GP's, district nurses and dieticians. The deputy manager explained how the agency maintained close relationships with the local manual handling team by doing online referrals for reassessment of equipment when required and following their advice. We asked people if care workers had been in contact with healthcare professionals on their behalf, one person said, "Yes, if I asked them to", other person commented, "One carer told me my skin was very dry and suggested that I contacted the GP to get a cream, I did it and they (carers) now apply it." One community professional commented, "They think about alternatives; go above and beyond; go that extra mile." This meant that people were being appropriately supported to seek advice from other professionals to prevent their health deteriorating.

Good

Is the service caring?

Our findings

We asked people using the service and their relatives if staff were kind to them. Two people told us, "Yes." Another person said, "They are very nice girls." A third one said, "Yes, they are all very helpful, if I need anything doing I'll ask them and they are there to help." Relatives told us, "My relative likes them and the ones I met are caring." Others commented, "Yes, definitely" and "They are very responsible, caring and responsive."

We checked if people and their relatives were being involved in planning and reviewing their care.

The registered manager and deputy manager explained they met with people on a regular basis to review their care. This was done by agreeing a mutually suitable date and time by telephone to meet at the person's home. We confirmed this when we spoke with people and their relatives. One person said, "Yes I was involved." One relative said, "Yes, they came to visit us the first time, they came out and explained everything. They come every 12 months or before to ask how we are." Another relative said, "We have regular assessments done, at least every 12 months. I am very much involved in reviewing the care." By looking at people's care records we could evidence that reviews were done regularly. This meant that people and their relative's views were frequently consulted and reviewed to ensure care was provided according with people's preferences and needs.

We considered if people's privacy and dignity was being respected. Care workers could describe how they respected people's privacy whilst providing care. One said, "When we do personal care we need to make sure the person is not fully undressed, we close the door and the curtains." Others told us, "Each visit is unique, I don't talk about other service users, we don't discuss other people." This was corroborated by the views shared by people and their relatives. One relative said, "Yes, (carer) closes the bathroom door." This meant staff provided care in a respectful and considerate manner.

During our inspection, we saw people's files with confidential and sensitive information were stored securely in the office. The service had started to use a new system to store and access information; this was an internet based system and was going to be fully operational in August 2017. Care workers were able to use this system by using an application in their work phones which allowed them to access care plans, risk assessments and record daily care provided. We asked the registered manager about the security measures in place to protect people's confidential and sensitive information. The registered manager told us the new system required a two level password access, it had a timed log out and care workers could only access to people's information if their care visits were allocated to them. We asked the registered manager if they had a specific policy in regards to managing electronic information using this new system, they said they didn't have a particular policy but the system was recognized by the accredited scheme ISO27001.

The registered manager told us that people's cultural needs and preferences were assessed. For example, we saw records that included one person that preferred their personal care to be delivered using an Islamic/Muslin technique (where people are never completely undressed). We spoke with staff who were able to describe this.

The registered manager told us no one was using advocacy service now but one person had used advocacy services before. They were aware who to contact to obtain the services of an advocate. The registered manager explained that they would refer people for advocacy if the person needed help with making decisions. This meant that people could be supported to put forward their views if this support was required.

Good

Is the service responsive?

Our findings

The registered manager told us they assessed people prior to commencement of service. This assessment included the completion of risk assessments, description of a person's life history, needs and preferences, including frequency and times of visits and staff's capacity. The registered manager explained the usual procedure when a new care package was accepted which included visiting the person at their home and introducing the main care workers that would regularly provide the care. The registered manager told us after they had provided the service for a week they would telephone the person for feedback on the care provided and after a few weeks the registered manager would undertake spot checks at the person's home to ensure care was being provided as required.

People and relatives confirmed this had been their experience when first starting to be supported by Horizonz Care. One relative said, "Yes, they came to visit us the first time, they came out and explained everything." Another relative said, "Yes, the manager came out with three or four carers to introduce them, but [relative] usually has the same one. They (care workers) have been brilliant with [relative]." This meant the service was assessing people's needs and the service's capacity to meet those needs before taking on new clients, ensuring that they were providing individualised and sustainable care.

When we looked at people's care plans, we found specific care plans and risk assessments were in place to identify people's needs, preferences and support required. Examples of care plans included mobility, bathing and washing, dressing, eating and drinking, toilet and continence, skin, behaviour, finances, memory and resuscitation. Each person's care plan had a detailed description of what care staff should do in each care visit and how to offer it to people. One person's care plan stated 'upon entering, support workers will greet [person] to ensure she is well; they will let [person] complete their exercise before the transfer takes place'. Another person's care plan stated their preferences in relation to when to be supported, '[person] likes to get up at 10:00; [person] likes to have a shower at 10:00; [person] likes to go to bed at 21:00'. We checked daily notes and saw that people were being supported according with their needs and preferences. Care plans included a health assessment which detailed the particular health conditions of the person, for example, one person had detailed information about epilepsy, dementia and depression. This meant that information in the care plans had been designed to help staff meet people's specific care needs by providing staff with detailed guidance.

We spoke with staff who were able to give a detailed description of people's care needs and preferences. One said, "[Person] has Cavillon cream to apply if [person's] skin is dry and sore; [person] will ask for it." Another care worker said, "[person] is a double up, we use a rolling technique." When we spoke with people and their relatives we asked if this was happening and they confirmed that staff was providing care in line with their preferences and needs. One person said, "I always have a shower on a Wednesday, is the day that I picked." One relative told us, "If (relative) wants fish and chips there is money in the house, the carers help [person] buy it and they bring the receipts."

We checked if people were receiving consistent personalised care. The registered manager explained that care workers were divided in two groups, morning and evening. This meant that people were consistently

receiving care by care staff that knew them well.

During our inspection, we asked if people and their relatives knew how to raise a concern or make a complaint. One person told us, "Never had to do a complaint, touch wood." A relative commented, "Not at all but I would know how by contacting the manager and if not acted upon I would take it further." Another relative commented, "Never done a complaint; if I had concerns I would ring them."

The registered manager was able to explain to us which steps they would take if they received a complaint, these included gathering information, documenting what had been agreed and actions taken. This was in line with the complaints policy found on file. This policy included timeframes for the actions to be taken by the agency and contacts for the Local Government Ombudsman and CQC. We saw complaints were recorded in a book but none had been raised since August 2016. We read previous complaints on file and we saw that details of the actions taken had been clearly documented. This showed that people and their relatives could voice their concerns and be reassured that these would be valued and acted upon.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the service who was also the registered provider and had been managing the service since its registration 2014.

During our last inspection in June 2016 we identified the registered provider was not following the regulations in relation to good governance because the auditing process was not robust enough to ensure appropriate monitoring of the quality of the service. On this visit, we checked and found that the registered provider had made some improvements and was no longer in breach of this regulation. However, the standards of the quality assurance processes were not always consistent which meant they had not identified the issues we found at this inspection.

During this inspection we saw the registered manager conducted audits to different areas of the service. Some care plans were audited in areas such as people's involvement in planning and care plan, care plan, risk assessments, health assessments, medication support plan, moving and handling screen. These audits were well organised and included date of completion, action required, action taken and who completed them.

We saw evidences that regular spot checks to monitor care worker's performance and competence were done by either the registered manager or the deputy manager. The areas monitored included if the care worker was using the appropriate personal protective equipment, how people's dignity had been respected, how communication had been maintained with the person receiving care, and if the care worker offered support in a caring way.

The registered manager carried out regular medication audits. These focused on analysing the MAR's and checking if there were no gaps in signatures. The registered manager also did regular spot checks on staff administering medicines. Care workers confirmed regular and unannounced spot checks on medication were done, one said, "I've had some spot checks and then I got feedback after the call." However, the medication audits and spot checks did not identify any of the issues we found with medication during this inspection and were not in line with up to date nationally recognised guidance from NICE. We spoke with the registered manager about these concerns and they assured us they would consult the guidance and make the necessary changes to their medication audit.

This meant that at the time of this inspection the provider had systems in place to monitor the quality and safety of many aspects of the service however, some of these were not robust as they could be.

People and relatives we spoke with shared positive comments in relation to the registered manager and the way Horizonz Care was run. One person told us, "Yes, I am highly satisfied." Another person said, "It's all good, as far as I am concerned; we get on very well." One relative commented, "Yes I do. (Registered manager) is approachable." Another relative commented, "Yes, (the registered manager) does listen, she is 100%, every time I ring or leave a voicemail she rings back."

Care workers spoke positively about their working environment and the culture of the service. Care workers spoke passionately about their jobs. One care worker said, "You have to have a caring nature to do this job"; another said, "I do all my best for them." Care workers felt supported by the registered manager, one said, "She is awesome. She is approachable, any issues I can talk to her." One community professional commented, "They are doing a really good job."

There were systems to ensure effective communication including text messages and phone calls from the provider updating staff on changes to individual's wellbeing but staff also told us they were in regular contact and updated each other. During this inspection, we could see regular management and staff meetings were taking place. We read some meeting minutes and saw the themes discussed included updates on people's needs, training, confidentiality, staffing and time keeping. One community healthcare professional told us "Communication is really good; feeding back to me; record keeping is good." This meant the registered manager had effective systems in place to ensure internal and external communication circulated appropriately and benefited the quality of the care provided to people.

The registered manager and deputy manager told us satisfaction surveys were being sent to people who used the service and their relatives on a regular basis, two to three times a year, via post or email according with people's preferences. We saw evidences of replies sent by people and their relatives. The responses varied but were mainly positive. One person said, "Everything going really well", other commented, "Very satisfied", one relative said, "Don't always ring back." This meant the registered manager was involving people and relatives in how the service was run.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. At this inspection we saw the ratings from the last inspection were displayed in the office's lobby. The ratings were not displayed in the website. We spoke with the registered manager about this and they informed us of ongoing issues accessing their website in order to add new information but they would take tougher actions to solve the problem. We checked Horizonz Care's website before finalising this report the ratings were displayed.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we found the registered manager was meeting their responsibilities in relation to notifications.

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 11 HSCA RA Regulations 2014 Need for consent The service was not consistently implementing the Mental Capacity Act 2005 as they were not undertaking decision specific capacity assessments.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment process was not always robust.