Mrs Helen Lise Cass

Safe Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Safe Care provides domiciliary care and support services to people with individual needs in their own homes. At the time of our inspection 29 people were being supported by the staff with personal care and a further eight were supported with domestic and wellbeing visits.

This inspection took place on 6 February 2018. This was an announced inspection which meant the provider had prior knowledge that we would be visiting the service. This was because the location provides a domiciliary care service, and we wanted to make sure the provider would be available to support our inspection, or someone who could act on their behalf.

The service is registered as an individual provider and does not require a registered manager to be in place as the provider was in day to day control. The individual provider is responsible for the day to day running of the location, and has the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

This service was rated Requires Improvement in May 2016 and the provider was found to be in breach of three regulations. The service was re-inspected in July 2017 and was found to have remained in breach of the three breaches and a further three breaches of the Regulations were found. We took enforcement action against the provider for the overall rating of repeated 'Requires Improvement'. We imposed a positive condition on their registration, issued a fixed penalty notice and serve a Warning notice. The provider is not able to take on any new packages of care without the prior written agreement of The Care Quality Commission and submits monthly reports including written records of staff training, audits of care plans, risk assessments and all quality monitoring conducted within the service.

At this inspection we found the service had made some improvements to meet three of the six breaches of Regulations, but however still remained in breach of three Regulations. This is the third consecutive time the service has been rated as Requires Improvement. Therefore the positive condition will remain on the provider's registration at this time. The provider will continue to submit monthly reports so we can monitor this service and they are unable to take on any new packages of care until further agreement from The Care Quality Commission. Due to the on-going concerns we will met with this provider to seek assurance on how they will address these concerns without delay. We are now taking further enforcement action and will report on this when any representations have been concluded.

The provider and the assistant manager had spent time since our last inspection creating a risk assessment template that they felt was appropriate. However, at this inspection this was only in the early stages of being put in place and some care plans we reviewed did not have risk assessments in place and the one's that did were not fully completed. One person's care plan stated they had a history of falls and their carpet was loose. It recorded that the person's walking aid would sometimes get stuck in the loose carpet which was a trip hazard. A risk assessment was in place but made no mention of this loose carpet or how staff should support the person safely in light of this risk. The service remained in breach of this Regulation.

Improvements had been made overall to the management of medicines. However when the service did not support someone with medicines this needed to be made clearer in the medicine support plan.

The care plans we reviewed were still not in an organised format. The provider and assistant manager told us they had struggled with the conflicting information received on developing their care plan format. 13 out of 37 care plans had the new template in place, however not all aspects of the person's care were detailed. This meant a completed working care plan was not available The service remained in breach of this Regulation.

The provider had failed to meet their registration condition to submit monthly reports around risk assessments, care plans and of all quality monitoring conducted within the service. Improvements had not been made in a timely manner to ensure the service was safe, responsive and well-led. The service remained in breach of this Regulation.

The provider had ensured that all staff completed the required training to effectively fulfil their role. We saw that each staff had a training development plan in place which included regular observations, one to one meetings with the provider and an annual appraisal

People continued to praise the care they received and gave positive feedback about the staff who supported them. People told us "It's very important to me that I only have a few carers who I know well, and that happens. If a new carer is starting, the managers will bring them out, introduce them to me and show them what to do" and "For me, they are my lifeline. I can't praise them highly enough. Professional, well trained and just willing to take whatever time is necessary to get things right."

The provider monitored the care people received through regular reviews with people, surveys and observations of staff. People were encouraged to be at the forefront of any care decisions made.

Staff attended team meetings and told us they felt well supported by the management in place and able to raise concerns when they needed.

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.

Risk assessments had not always been put in place when there was an identified risk to a person. Some risk assessments did not have effective information recorded on how to minimise the risk.

The service followed safe recruitment practices and had sufficient numbers of staff. People received their visits on time by regular staff members that they knew.

Improvements had been made overall to the management of medicines. However when the service did not support someone with medicines this needed to be made clearer in the medicine support plan.

Is the service effective?

Good

The service was effective.

The provider had ensured that all staff completed the required training to effectively fulfil their role.

Staff responded well to any health concerns they had about people and took action to support them to see the appropriate health professional.

Staff were able to explain how they applied the principles of The Mental Capacity Act into practice. One person who lacked capacity did not have an assessment in place.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Requires Improvement

The service was not responsive.

Information still needed to be updated or added to people's care plans and the files had not been organised to show people's current needs.

People were given the opportunity to discuss their care needs on a regular basis.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to meet their registration condition requesting them to submit monthly reports around risk assessments, care plans and of all quality monitoring conducted within the service.

Improvements had not been made in a timely manner to ensure the service was safe, responsive and well-led.

People, their relatives and staff spoke highly of the provider and assistant manager and felt involved in and well supported by the service.

Safe Care

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 was a comprehensive inspection that took place on 6 February 2018. This inspection was announced, which meant the provider was given short notice that we would be visiting. This was because the location provides a domiciliary care service to people in their own homes, and we wanted to make sure the provider would be available to support our inspection, or someone who could act on their behalf

The inspection team consisted of one inspector who undertook the visit to the office location and an expert-by-experience who made phone calls to people and their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The service was previously inspected in May 2016 and the provider was found to be in breach of three of the regulations. The service was rated as 'Requires improvement'. The service was re-inspected in July 2017 and was found to have remained in breach of all the three breaches and a further three breaches of the Regulations were found. We took enforcement action against the provider as a response to the overall rating of repeated 'Requires Improvement'. The enforcement action we took was to impose a positive condition on their registration, issue a fixed penalty notice and serve a Warning notice. The provider was not able to take on any new packages of care without the prior written agreement of The Care Quality Commission and had to submit monthly reports written records of staff training and audits of care plans, risk assessments and all quality monitoring conducted within the service.

At this inspection the provider continued to be in breach of three of the Regulations and is rated as 'Requires Improvement' for the third consecutive time. We are now taking further enforcement action and will report on this when any representations have been concluded.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service.

A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with five people who were using the service and six relatives by telephone. We looked at the care records of seven people and four staff recruitment files. We also looked at records relating to all aspects of the service including care, staffing, training and quality assurance. We spoke with the provider and the assistant manager. Two staff provided feedback to us after the office visit.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2017 the service was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's personal safety had not always been assessed or plans put in place to minimise these risks and provide guidance to staff.

The CQC imposed positive condition on the provider to submit a monthly report which included how they would address risk management systems.. The provider failed to meet this condition and did not submit monthly reports around risk assessments. At this inspection on 6 February 2018, we found that the service had not taken enough action needed to meet this Regulation and remained in breach.

The provider and the assistant manager had spent time since our last inspection creating a risk assessment template that they felt was appropriate. However at this inspection this was only in the early stages of being put in place so some care plans we reviewed still did not have risk assessments in place and the one's that did were not fully completed.

Individual risks to people were identified but risk assessments were not up to date on how to minimise the risk. We reviewed one person's new risk assessment which listed the risks including risks of falling in the shower, falling when walking, falling when transferring from their bed to chair and falling when out and about in the local community. We spoke to the provider about making it clear on the assessment what the overarching risk was, For example, falls was the risk for this person. We saw that control measures stated there was a safety gate at the top of the stairs and a non-slip bathmat. However there was a lack of information in explaining how this prevention was to be maintained by staff, such as when it was appropriate to have the safety gates locked, or putting the mat down when supporting with care. There was no date recorded of when this risk assessment had been completed or by whom, or when a review would be due. There was space to record the type of equipment being used, who had responsibility for the maintenance and servicing of this but it had not been completed. The assistant manager told us this assessment was still being finished off and tweaked on the computer.

One person's care plan stated they had a history of falls and their carpet was loose. It recorded that the person's walking aid would sometimes get stuck in the loose carpet which was a trip hazard. A risk assessment was in place but made no mention of this loose carpet or how staff should support the person safely in light of this risk. The care plan later contradicted the earlier statement by documenting that the person's environment was all level and there were no uneven areas. The provider told us they were currently completing a new risk assessment to include this. We saw that the care plan stated an occupational therapist referral was needed but there was no further information on if this had been done yet or subsequent outcomes. The care plan had been written in August 2017.

At the last inspection in July 2017 we found there was no risk assessment in place for a person that was being taken backwards in their wheelchair by staff as their feet would drag along the floor. We saw this information was still recorded in the person's care plan and a risk assessment was not in place. The provider

told us this person now had a new wheelchair and staff could us it appropriately; however this information had not been updated in the care plan. Another person's care plan said they needed a skin integrity support plan to be in place; however this had not yet been done.

One person's care plan identified several risks around their mobility, health and skin integrity. The person had been scored as a high risk because of these factors. However there was no risk assessment for any of these concerns in the care plan to ensure they were being appropriately managed. Another person's care plan stated that this person had a diagnosis of dementia and staff were to leave the door unlocked as they could be left alone for periods of time. Although this had been agreed with the person's relative the provider had not completed a risk management assessment around this for when staff would leave this person alone and the door unlocked. This meant the person was left in a potentially vulnerable situation.

We saw that one person did not have any information recorded on how staff were to support them with their continence needs. There were also no risk assessments in place around the person's mobility or pressure ulcer risks. The provider told us they would be putting risk assessments in place using their new format and rewriting the care plan for this person. However these concerns had been discussed at the previous inspection and timely action had still not been taken.

This was a breach of Regulation 12 (2) (a) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they had not experienced any missed visits and staff arrived on time. One person told us "I have never experienced any missed calls whatsoever. In fact, my carers are always on time. They were only ever held up with a medical emergency, once, and then, they phoned me so I knew what was happening." One relative commented "My sister has never had any missed calls. Very rarely, if they are running late, someone will always call her to let her know." Staff had no concerns about staffing levels and had enough time to support people appropriately. The provider and assistant manager were not covering as many support hours now and spent most of their time in the office. The provider told us they hoped in the future to take on four new seniors who would be responsible for covering staff annual leave and sickness so this would reduce even further. During this inspection the provider and assistant manager attended a support visit.

The service followed safe recruitment practices. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. The provider told us the same recruitment procedure was applied to all new staff and they completed the same training.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting any concerns. Staff commented "I would report concerns to my manager in as much detail as possible" and "I would report it to my manager, log it and sign and date the incident. I haven't experienced this." One relative praised the service and staff for the support they had given their family member commenting "They are certainly my lifeline. Mum is still living in her own home, which is important to her. She couldn't, if she didn't have these carers coming in. They have worked really hard with her, helping her to build up her confidence and regain some mobility following her operation. I can't praise them highly enough."

The provider had updated the medicines policy since our last inspection to include information on medicine prescribed for 'when required' use (PRN). We saw that some medicine plans were in place describing how a person took their medicines even though staff did not support the person with taking their medicines. We spoke with the provider about making it clearer on the front of the support plan if they did or did not

support people in this area. One person would also be left alone with their medicine and staff did not witness them taking it but continued to sign the administration record. The provider said they would address this and make it clear that staff signed to say the medicine had been dispensed ready for the person, but the administration was not witnessed.

People's medicine care plans had been updated and where topical medicines were applied, a clear body map was in place detailing information about the application of each medicine. The care plan recorded what medicine a person had been prescribed, how their medicines were obtained, details of their GP and any allergies the person had. Staff had guidance on how the person liked to be supported with their medicines. There were reminders on checking and signing medicine records and to ring the office if there were any concerns. A separate page was in place to list any changes made to a person's medicines and who had authorised this. This meant staff had current information available and were kept informed if the GP had prescribed any new medicines or stopped any.

People and their relatives told us they were happy with the medicine support they received commenting "I have my tablets which are given to me by my carer with a drink, and I take them, before my carer writes it up in the records" and "She has all her tablets in the dossette box, so the carers hand them to her with a glass of water and once they've seen her take them, it gets written up in with the notes." A dossette box is a disposal plastic system for arranging weekly medicines.

Good

Is the service effective?

Our findings

At the last inspection in 3 July 2017 the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received all the required training relevant to their role in order to effectively meet people's needs. The provider had a positive condition imposed on their registration to submit a monthly report which included how they would address staff's training needs. At this inspection on 6 February 2018 we found that the service had taken the necessary action and were no longer in breach of this Regulation.

The provider had ensured that all staff completed the required training to effectively fulfil their role. Further to this a system had been implemented in which staff attended monthly refreshers to keep their knowledge current. New staff completed the Care Certificate modules, medicines and manual handling training and then joined the other staff for the monthly refreshers. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The provider told us two staff that had been with the service a long time were also completing the Care Certificate. One member of staff said "I do medication, I have done the course. I double check each client's name and what they take. I have done my National Vocational Qualifications (NVQ) level two and three and all course I've been given. Safe Care has a record." NVQ's were work based awards achieved through assessment and training. These have evolved into the Regulated Qualifications Framework (RQFs) which came into force in 2015.

We saw that each staff had a training development plan in place which included regular observations, one to one meetings with the provider and an annual appraisal. The provider completed the same training as staff so they were informed on what they had learnt. People and their relatives felt staff were knowledgeable and confident in the care they provided commenting "I think they are exceptionally well trained. On top of that, if they're introducing a new carer to, [the provider] will accompany to give them specific training for my relative's needs" and "I've got no reason to think that they're not trained properly. I mainly see two staff and they can do everything I need without me having to remind them all the while."

New staff were supported to complete an induction programme before working on their own. One staff told us "The manager sat and answered all of my questions and explained scenarios and situations. I was also told about the rules and regulations."

For people that were supported with food and drink a meal plan was in place showing the person's likes and dislikes and where they enjoyed having their meal and the support needed. One person told us "Between mealtimes, my carers will usually leave me a few biscuits and I've usually got a bowl with some fruit in as well." One relative said "My relative never gets very hungry these days, but her carers sometimes try to tempt her by leaving a nice cake or some fruit out for her whilst she is on her own."

We saw guidance was available in people's care plan about a specific health condition they may have so staff could be informed. The service continued to work well at making timely referrals and helping people seek appropriate healthcare when required, however recorded information from health professionals was not always present. The provider said they had struggled with other health professionals leaving notes on

bits of paper when they had visited and put something in place for staff to follow. They did not always leave information or contact the service to inform them of these changes. The provider told us they were going to put a professional's visit page in the care plan for health professionals to record changes and updates on and email all the teams that visit to make them aware they would like this to be used. The provider said they would inform local health and social care professionals involved with the person to start writing information on this form.

Relatives told us the staff responded well to any health concerns about their family and took action to support them to see the appropriate health professional. Comments included "If they are ever concerned about my relative, they will tell me straightaway and I will arrange for someone to come and see him. Sometimes, because I'm here all the while, I don't always notice particularly small changes in his health, so I'm grateful to them" and "They will always call me if they are any way concerned about Mum. I then usually go and see her and we decide what next steps are needed. The assistant manager will always ask if they can be of assistance also."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The registered manager confirmed this didn't apply to anyone receiving the service at the time of this inspection.

People were involved in the creation of their care plan and their consent to care was recorded. It was recorded if consent was given verbally or the care plan would include the person's signature. During this inspection we saw one person's care plan recorded that they now lacked the capacity to consent to care. Their relative had a Lasting Power of Attorney (LPA) in place; however a capacity assessment had not yet been completed for this person. LPA is a legal document that lets a person appoint someone to help them make decisions or to make decisions on their behalf. We saw that this LPA document had been recorded on the person's file. The provider told us they would seek advice and support from the local Deprivation of Liberty Safeguards (DoLS) Team around completing this capacity assessment.

Staff were able to explain how they applied the principles of MCA into practice. One staff told us "I understand that MCA is where the law comes in about people who can't make their own decisions. This therefore protects them when they are vulnerable to people who may take their will away from them, so they can still make choices." The provider told us "We find out as much as possible at the initial assessment and encourage staff to always offer choice around mealtimes, clothes etc."

Good

Is the service caring?

Our findings

People continued to praise the care they received and gave positive feedback about the staff who supported them. People told us "It's very important to me that I only have a few carers who I know well, and that happens. If a new carer is starting, the managers will bring them out, introduce them to me and show them what to do", "I like everything about them. I just have a few regular carers, which I like, they all wear their uniforms and have their disposable gloves and aprons and they are all so friendly", "They appear on time, they never rush me and they never mind doing extra jobs, even without me asking them. I can't ask for anything more" and "For me, they are my lifeline. I can't praise them highly enough. Professional, well trained and just willing to take whatever time is necessary to get things right."

Relatives felt their family member were well cared for by staff that knew them well. Comments included "It was extremely important to us that my relative has continuity of care and we told the assistant manager that at the beginning. She has consistently delivered this and we have been very impressed with them. New carers are always brought round and introduced and they shadow for a couple of times before coming on their own" and "They come and help me with Dad, but if they hear my Mum say that she fancies something, or is running out of anything, they will bring it in for her next time they come. They are very thoughtful like that."

The provider monitored the care people received through regular reviews with people, surveys and observations of staff. The provider and assistant manager continued to undertake some care visits which allowed them to regularly speak with people directly and ensure the care they received was appropriate. One staff told us "I keep all confidentiality to myself in the work place, what is at work stays there. I am supportive and easy to talk to with my clients and if they feel upset or down I do my best to cheer them up and turn the situation around to make it better."

The staff promoted people's human rights and encouraged staff to take an individualised approach to providing care dependent on the person's needs and wishes. The provider told us "I have a chat with people about what they can do, the staff complete dignity training and we include people in throughout the care planning and assessments."

People were encouraged to be at the forefront of any care decisions made. The provider told us "People like that we ask a lot of questions, it's their home and I want to make sure I put things away where they want them." People felt their decisions were respected by the service commenting "I chose the day and times of my calls and I was able to decide whether I preferred male or female carers", "I can usually hear them asking my wife if she's ready to make a start each morning" and "I do tell them that they don't really have to ask me all the time if I'm ready to start, but they continue to do so." One relative told us "We were certainly asked about times, days and preference of carers and my relative has been able to tell them if he hasn't got on too well with anyone. Also, if he doesn't feel like getting up sometimes, no one ever forces him to."

Staff continued to support people to maintain their independence as much as possible. One staff member said "I ask my clients if they would like to do certain tasks themselves rather than go in and do it myself right

away." People told us they felt well supported and care was provided in the way they preferred saying "I couldn't have my daily shower without them because if I try to reach right down the back of my legs, I can easily over balance. I like having my shower and want to continue for as long as I can", "I've just reduced the number of calls I have every day, because now I find that I can look after myself and do not need them at teatime anymore", "My carers are good and will allow me the time to do what I can for myself. I remember my mother saying to me, if you don't use it, you'll lose it" and "When I have my shower, my carer is there to support me, as I only have to call if I need help, but they certainly don't stand there staring at me while I wash. They give me my privacy which I need."

People spoke fondly of the staff and mutually trusting relationships had developed between them. One relative told us "I was surprised when my relative told me that her favourite carer is a male, but she tells me that he is the most caring of all of them and when he washes her hair, he takes his time and ensures every last bit of shampoo has been rinsed out." Another relative commented "Everyone has a small number of regular carers who they know well. They arrive on time, don't rush people and allow them the space to do what they can for themselves. I was told that they arrive on time and are always willing to do extra jobs when they're needed."

Requires Improvement

Is the service responsive?

Our findings

At our inspection in May 2016 the service was found to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not very person centred and where people had a specific health need there was not always clear information in place and documents were not always completed appropriately. There were no end of life wishes documented in people's care plans. An action plan was submitted by the provider which stated they were to address this situation without delay.

At our last inspection on 3 July 2017, we found that the service had not taken the required actions needed to meet this Regulation and remained in breach. The CQC imposed a positive condition on the provider to submit a monthly report which included how they would address this concern. The provider failed to meet this condition and did not submit monthly reports around people's care plans.

At this inspection on 6 February 2018, we found that the service had still not taken enough action needed to meet this Regulation and remained in breach. This is the third consecutive time the provider has been in breach of this Regulation.

The care plans we reviewed were still not in an organised format. The provider showed us an example folder they planned to follow which was split into different sections; however there was not one fully completed care plan for us to view in this style. The provider and assistant manager told us they had struggled with the conflicting information received on developing their care plan format. They understood however that the ultimate responsibility lay with them to ensure these were in place and were effective. The provider told us "We are still working on the care plans as we are trying to get the templates and the format right. It's taken time to learn the format of what templates we want to use."

The provider informed us that 13 out of 37 care plans had the new template in place, however there were aspects missing which included, risk assessments or parts that needed adjustments. There was no finished working care plan in place. The provider told us they had spent a long time on this saying "I think things through; I don't like to put any old thing in place. I want to choose a format that suits everyone. However this meant that since our last inspection the care plans had not been progressed enough to provide sufficient information on each person's care.

The provider explained they had sent a letter to people requesting they complete background information about themselves to include more social life history into the care plans. However they reported that this had not been favoured by people who told them they could just ask what they wanted to know. These conversations with people had either not yet taken place or were still in the process of being recorded into people's care plans using the new template. We saw some information was recorded on loose pieces of paper and were mixed with other parts of the care plan. The assistant manager said this information was waiting to be written up on the computer but they had not yet got around to doing this.

It was still hard to ascertain the most up to date care plan. Some initial pre-assessments had been archived

and other care plans had different dates recorded and were filed in no particular order. We reviewed one person's support plan dated 31 May 2017 and then further on into the folder was another support plan dated 27 August 2017. Some care plans and assessments did not have any dates recorded which meant it was not known how up to date the information was.

People's care plans often contained incorrect information which had not been picked up during any audits or amendments made. For example one person's care plan stated they had a food allergy, however no information about what this was and how to support the person around this was recorded. The assistant manager told us they had marked the wrong box and the person did not actually have a food allergy. Another person's file stated that due to their beliefs a religious care plan needed to be put in place; however this had not been done. One person's care plan referred to them as a being male and used the word 'his' in several areas, however the person was a female. The assistant manager told us this must have been overlooked when they transferred the information across.

We looked at the new style of care plan and whilst it contained a lot of personalised information it was not user friendly. Some care plans were several pages long and there were no spaces between the words so it read as one long continuous block of words. It was hard to access different parts of the person's care needs such as nutritional needs or personal care needs or mobility needs as it was all intertwined as one long story. We spoke with the provider about the level of minute detail they had recorded, such as how much soap to put on a person's flannel, as nearly everyone they supported had capacity and would be able to recall this kind of information during their daily care interaction. The provider told us they had considered having a profile at the start of the care plan with the' need to know' information on and then include the further detail elsewhere in the care plan. The provider also realised the format was not easy to read and needed to be rearranged into manageable chunks for people and staff to follow.

At our last inspection on 3 July 2017, the provider had told us they would seek external professional guidance on completing end of life care plans with people. At this inspection we continued to see that there was no information recorded around this area in people's care plans. The provider told us that the people they had asked did not seem to want to talk about it. We spoke with the provider and assistant manager about how they could approach this style of conversation and focus on the care element of people's wishes. The provider said they needed to continue exploring this area and record any outcomes in the care plans.

Although the provider was aware of the Accessible Information Standard (AIS) they had not taken action to implement this further into people's care plans. AIS was introduced by the Government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. Where a care plan stated a person had a communication need, information was not recorded on how this affected their daily communication needs and what things had been put in place to support them with this need. The provider had taken some action around this and staff had completed sensory impairment training to be aware of people's needs when supporting them. The provider informed us they needed to develop the communication support plans for people with this need, so what was happening in practice was also recorded.

We reviewed the daily records that staff completed and found that when concerns were recorded there was no information about the action that had been taken around this or if senior management had been informed. For example we saw the staff had recorded their observation of one person possible healthcare deterioration. Another person had a sore toe but it did not record how this was managed. The provider told us they were going to put a new format of record keeping in place to make it clearer for staff to report their concerns and not to assume that someone else has done it. The daily records were currently being collected monthly and the provider hoped that the new senior staff role would check these daily records more

frequently.

This was a breach of Regulation 9 (3) (a) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider regularly contacted people to make arrangements for a review meeting to discuss their care needs and any changes required. On joining the service people were offered a review after one month, six months and then an annual review or when it was next needed. The provider had implemented a new form to document any changes to a person's care which recorded the change and action taken to meet this. One person said "The Care Plan was originally put together when we first met with the provider some time ago. Since then, it's been updated when the assistant manager came out to see how we were and to check whether the support was going alright."

Only one concern had been raised with the service since the last inspection. We saw the provider had taken the appropriate action to ensure the person was satisfied with the investigation and outcome. People continued to be made aware of how to make a complaint if they needed but told us they had no need to do this and that they highly valued the service they received. Comments included "If I had any concerns, I'd speak with the manager, but I don't" and "We met the provider originally, but have since got to know the assistant manager as well, so we'd probably approach one of them with any problems. So far, though, we've been nothing but happy with everything."

Requires Improvement

Is the service well-led?

Our findings

The service is registered as an individual provider, and therefore a registered manager does not need to be in post at the service. The provider managed the daily running of the service and was referred to as the manager by people, their relatives and staff.

At our inspection in May 2016 the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to monitor the quality of care and support that people received. An action plan was provided by the provider which stated they were to address this situation without delay. At our last inspection on 3 July 2017, we found that the service had not taken the required actions needed to meet this Regulation and remained in breach.

We took enforcement action and imposed a positive condition on the provider's registration, in which they had to submit a monthly report including how they would address this concern. The provider failed to meet this condition and did not submit the monthly reports around risk assessments, care plans and of all quality monitoring conducted within the service. At this inspection on 6 February 2018, we found that the service had not taken enough action needed to meet this Regulation and remained in breach. This is the third consecutive time the provider has been in breach of this Regulation.

The provider had recently put a form in place to start documenting the quality monitoring of the service. The provider sent us this form for the first time in January 2018, however it had been a condition imposed from the last inspection that this was to be sent monthly from that time. The provider told us they had been trying to be more organised and put things in files to make locating documents easier, commenting "I know I should have been sending these audits monthly, but I needed to think about how to set this up, this will now be done every month."

We reviewed the quality monitoring form in place and saw it recorded numerical information around new people to the service, new staff, hospital discharges and admissions, complaints, compliments, falls and staff supervisions and training. The information was only in this format and no further analysis had been considered with this information in terms of reviewing the service, informing practice or identifying concerns and implementing change. The provider understood that further work was needed to ensure the information gave them full oversight of the service.

The quality monitoring tool did not have any information recorded about auditing medicine records or daily records. The provider told us the recording needed further development and they checked these records but had not documented these checks yet.

The provider did not have an action plan in place to record the improvements the service were working towards and the timeframes to complete these. This meant it was hard to understand what the focus had been since the last inspection and the current actions. The provider said they needed to start recording their progress in an action plan and currently it was all kept in their head.

At this inspection we found that the provider had not made enough improvements to meet three of the Regulations and remained in repeated breach of these.

This was a breach of Regulation 17 (2) (f) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administrative staff would be taking on the responsibility of auditing people's care plan and staff files each month, to ensure the correct information was in the files and making any necessary updates. A communication book was used between the provider and administrative staffs to ensure changes were added to the system. The provider showed us their new spread sheet which recorded what documents should be present in each person's care plan so this could be checked against the person's file. The provider said when reviews of care needs were due or staff supervision this would be highlighted by the system to prompt staff. The provider said "When we are happy with the forms we will then start getting staff in to learn them and check they are happy with these to use."

An incident and accident folder had now been created with a detailed record to complete of the event. Any incidents would be signed off by the provider, and a record of what action was taken and who was further informed would be completed.

At our last inspection in 3 July 2017 the service was found to be in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.This was because services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. The provider had failed to report four notifications. We took enforcement action and issued the provider with a Warning Notice which asked that immediate action be taken to address the concerns.

After the last inspection the provider submitted all the late notifications and has continued to send necessary notifications to CQC. At this inspection on 6 February 2018 we found that the service was no longer in breach of this Regulation. The provider told us they were now aware of what needed to be notified and understood their reporting responsibilities.

At our last inspection in 3 July 2017 the service was found to be in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not displayed their ratings from the inspection in May 2016 on their website or at the location from where the service is run. We took enforcement action and issued the provider with a Fixed Penalty Notice. At this inspection on 6 February 2018 we found that the service was no longer in breach of this Regulation and the ratings were clearly displayed at the service and on the provider's website.

The provider was supported by an assistant manager and people and their relatives continued to speak highly of the management within the service. Comments included "We have seen both (the provider and assistant manager). They even stand in when carers are off ill, which we like, because it means they understand what her care needs are on a practical basis as well", "I have [(assistant manager's]) mobile number and she always tells me that I can contact her anytime. She has been really helpful in assisting us to access services for Dad. I couldn't have done it without her"; "I would definitely recommend them. I like the fact that I have three regular carers who I like, get on with, and they know both me and my husband well. I would be lost without them" and "I have recommended them already. My relative is not easy, but they have gone out of their way to make sure that she is happy. It hasn't been easy for her to accept a stranger providing her care, even for this limited amount of time."

Staff attended team meetings and told us they felt well supported and able to raise concerns when needed. One staff member told us "The management is lovely here, I can always get hold of them and they are very supportive. Safe Care is good for listening to their employers and help to meet your needs as best as they can. They are also great with equality and diversity in the work place. If you have a problem they will always talk to you and help resolve any issue or help you even if they aren't working." Another staff said "[Provider] is a very good boss and always here if I text her for support and on the other end of the phone."

The service promoted a positive open culture and included people in events affecting the service. We saw following the last inspection the provider had sent people a letter asking if they would like to be sent a copy of the inspection report. The provider told us their values were to "Provide a good care service; we don't have a high turnover of staff which gives continuity to people."

People continued to be given the opportunity to provide feedback on the service. A feedback survey was completed in November 2017 by 31 out of 37 people. The service scored high overall in people's satisfaction levels. The provider explained when issues were raised this had been investigated, discussed and resolved. One person told us "I filled in a survey a few weeks ago which asked questions about the service. Whenever I see [assistant manager], she also wants to know if I'm happy with everything." The provider said "Everyone feels it's a good service from the feedback and it's nice to know we are doing some departments well."

The provider had recently completed their manual handling update to enable them to train the staff in this area and the assistant manager had finished their level three management course. Further training courses were currently being looked at for staff development which included falls prevention, drug and alcohol awareness and working in a person centred way. The provider told us they also wanted to work towards building stronger links with external professionals and the community by clearing up the office and holding open days for professionals and relatives to meet them and staff recruitment days.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans continued to need further information, updates and organisation. It remained hard to identify the person's most current level of needs. Regulation 9 (3) (a).

The enforcement action we took:

The imposed condition remains on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's personal safety had not always been assessed fully or plans put in place to minimise these risks and provide guidance to staff. Regulation 12 (2) (a) (b).

The enforcement action we took:

A Notice of Decision to cancel the provider's registration was served.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to meet their registration condition requesting them to submit monthly reports around risk assessments, care plans and of all quality monitoring conducted within the service. Improvements had not been made in a timely manner to ensure the service was safe, responsive and well-led. Regulation 17 (2) (f).

The enforcement action we took:

A Notice of Decision to cancel the provider's registration was served.