HH Community Care Limited

Stocksfield and Haltwhistle

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17 and 19 February 2016 and was announced. This was so we could be sure that somebody would be available in the office, as it is a domiciliary care service. We last inspected this service in September 2014 and found no breaches of the regulations that we checked.

Stocksfield and Haltwhistle provides personal care and support to people within their own homes in Hexham, Haltwhistle and the surrounding areas. At the time of our inspection 318 people were active on the services register with over 140 staff members employed. There were a range of people using the service including older people, people with brain acquired injuries, people with learning disabilities and children. Staff supported individuals with a range of services from shopping only to full 24 hour care or enablement. Enablement is supporting people to do tasks they would not normally be able to do without support; for example, going out to the shops.

The service had a registered manager in post. 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.

The practice around medicines needed to be improved. We found information not always in place and staff were not always following safe management of medicines procedures.

Accidents and incidents were not always recorded and it was not clear whether they had been dealt with effectively by the provider. Where issues (including complaints) had occurred, actions had been taken but it was not always clear if lessons had been learnt.

We found people's records were not always up to date, including care plans, reviews and risk assessments. The provider did not have suitable procedures or practices in place to store records securely at their offices and archiving procedures were not effective.

People's care records were not always reviewed and elements of information was not always fully completed which meant that the provider could not be assured that people's care needs were fully addressed and tailored to the individual.

People told us that they knew how to complain and would if they needed to. People we spoke with said that complaints had been dealt with to their satisfaction, if they had made one. However, we found that the provider did not have suitable systems in place to allow us to confirm that complaints were dealt with in a timely and effective manner.

People and staff told us the service was well managed. However, we found no recorded monitoring checks in place for care records, medicines, accidents or personal files. We also found policy and procedure

documentation was out of date.

People told us they felt safe in the company of the care staff and that their belongings were secure. There were safeguarding policies and procedures in place. Staff knew what actions they would take if abuse was suspected. The provider had dealt with previous safeguarding concerns appropriately.

The provider had dealt with emergency situations, for example, adverse weather conditions and provided an out of hour's on-call system, manned by senior staff.

There was enough suitably recruited and vetted staff to provide quality care to people in their own homes. The provider had ensured the staff were trained to provide the care people needed. This included basic training, as well as more specialised training using healthcare professionals, when required. Supervision and appraisal systems were in place and staff meetings took place. Care staff told us that management were at hand to support them if they asked.

The registered manager understood the requirements of the Mental Capacity Act 2005. People were encouraged to make their own decisions and where they could not, best interest decisions were made. Although a record of a person's capacity was normally made available from care managers at the local authority, the service had not routinely detailed what that meant for care staff and how care staff would need to support the people with decision making. The service did not routinely (as part of the assessment process) ask for details of lasting powers of attorney, or if a person was under the court of protection. This meant that relevant details may have been missing in order that best interest decisions were made with the appropriate people involved. We made a recommendation to the provider regarding this.

People received suitable support with their nutritional needs, including adequate food and drink between visits. We saw evidence to suggest that where people required additional support from other healthcare professionals, like GPs, that the staff helped them to arrange this.

People told us the care provided by the staff was good. They remarked on how friendly, approachable and caring the staff were. The registered manager spoke about people with a caring manner and showed he was passionate about providing a good service to people.

Staff provided people with information that enabled them to understand the service they were receiving. People told us their independence was supported by staff at the service and they respected their dignity and privacy.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to regulation 12 safe care and treatment, regulation 16 receiving and acting on complaints and regulation 17 good governance.

The provider had not sent us notifications which are a legal requirement of their registration regarding, for example safeguarding incidents. After requesting further information we have judged these latest findings demonstrate an on going breach of regulations.

We used our enforcement powers with the provider for breaching regulations 12 and 17; and for regulation 16, you can see what action we told the provider to take at the back of the full version of this report.

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.

Medicines were not always managed safely.

Risk assessments and accident recording was not always completed fully and correctly.

People told us they felt safe and supported. Staff had received training in relation to safeguarding adults and said they would report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was aware of the Mental Capacity Act 2005, particularly in relation to the court of protection and lasting power of attorney, although there was a gap in the information recorded in people's records.

Staff were trained to meet the needs of the people in their care and communication was good between the staff teams and the management.

People received food and drink which met their nutritional needs and staff supported people with any additional healthcare needs, including appointments with GPs or going to hospitals.

Is the service caring?

Good

The service was caring.

People were complementary of the service and its staff and said that the care they provided was good. People told us that staff were dedicated and enjoyed their work.

People were supported to maintain their independence and retain their privacy and dignity. They were consistently treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always completed fully and reviewed regularly.

People knew how to complain although we were not always able to confirm if complaints had been dealt with effectively.

People told us they were involved in their care. The provider had established groups in the local community to help people avoid social isolation.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager at the service who was also the nominated individual. He came across as very caring and wanted to provide people with the best care possible.

The registered manager had not sent in notifications as legally required.

Policies and procedures were in place but needed to be updated to provide staff with accurate information and guidance to help them support people appropriately.

Stocksfield and Haltwhistle

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 17 and 19 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office when we called and also to give prior warning and arrange visits to people using the service. The inspection was carried out by two adult social care inspectors, one bank inspector, one expert by experience and one specialist advisor. 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 specialist advisor had a background in health and social care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including the notifications we had received from the provider about safeguarding concerns. We also contacted the local authority commissioners for the service, the local authority safeguarding team and the local Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection.

We visited nine people and spoke with 15 others who used the service. We also spoke with eleven family members/carers of these people. We spoke with the registered manager (who is also the nominated individual), a director, a clinical advisor, the training officer, two team managers, four administration staff (which included scheduling officers) and twenty three care staff. We observed how staff interacted with people and looked at a range of records, which included the care and medicines records for twelve people who used the service and ten staff personnel files. We also looked at health and safety information and other documents relating to the management of the service.

During the inspection we attended a team meeting which the registered manager had organised with eighteen members of care staff present. We spoke to them as a group after the meeting had finished.

Requires Improvement

Is the service safe?

Our findings

We found there were shortfalls in the safe management of medicines. We looked at the medicine records of people, including the Medicine Administration Record (MAR). We found there were some gaps in the recording of when medicines had been administered. We asked one relative about this. They said only one of the three care staff who came to their home were trained in medicines administration. This meant the relative had to administer medicines sometimes but they were not trained to complete the MAR. Staff were also not responsible for completing stock control checks of medicines and so we were not able to tell from MAR records if administration had been accurate. Where care staff had been trained in medicines administration, we saw documentary evidence that a senior member of staff had completed supervision and a competency observation whilst they administered medicines.

Other people had not been issued with MARs, and instead staff used a plain recording document to indicate when they had administered medicines. For example, the medicine records of one person were detailed and included the description, dose, time and date of the medicine. Whereas another record simply stated, "1 tablet given and taken with juice." When we asked a member of care staff about this, they said as the person only took one type of medicine and always in the same dose, this did not need to be recorded.

People's care notes showed that in some cases, medicines were regularly left out for people to take unobserved. The related care plans did not indicate if medicines had to be taken at specific times and were not always clear on actions staff should take. This meant there was a risk that people may take medicines at the incorrect time and not in the correct way. Care plans did not always include the details how staff should fully support people and relevant medicines risk assessments were not always completed. One person took Warfarin, but the risk had not been fully assessed. Warfarin is a medicine that stops the blood from clotting and is used frequently for people who run the risk of blood clotting (thrombosis) which can lead to heart attack or stroke. This meant staff may not have been fully aware of the risks or what action they needed to take if the person took more than the prescribed dose or missed a dose by accident.

Different formats were used to record accidents that occurred to people using the service. One person we visited, who received 24 hour care, had an accident book which would be used to record any accident/incidents. Four other people we visited did not have an accident book but said everything was recorded in their file. The difference in documentation could cause confusion between staff working at the service. Office staff, including team managers and the registered manager could not tell us of any reported accidents involving service users directly.

There were no accident forms relating to service users and we did not see any written evidence of accidents in people's care records. We did, however, find two accident forms related to moving and handling accidents. One accident involved a person falling through a sling onto the floor. The forms were not written in relation to any person's injury, but related to injuries caused to the care staff. Although accidents were recorded, they had been inadequately filed and were difficult to locate once archived. This meant that accidents were not always recorded correctly or stored appropriately and it was unclear if they had been dealt with effectively. We also found no evidence that accidents were monitored and analysed for any trends

forming, even though the provider confirmed they could review and analyse information by printing off the electronic entries for each individual. This meant that people may have not been fully protected from further accidents occurring.

We found there were risk assessments in place for care staff to be able to work in people's homes safely. Risk assessments had also been completed for example, in the safe care of people with a stoma and for people who needed support with personal care. Stoma surgery results in a small opening on the surface of the abdomen being surgically created in order to divert body waste to a pouch on the outside of your body. We found a number of people who were at risk of falls; however, there was no specific risk assessment around these concerns. We found some risk assessments were basic and did not include particular action for staff to take in case of an accident. For example, some people needed support to restock and light their coal fires. This required staff to carry buckets of coal and to stoke the fire. Although risk assessments included guidance for staff to protect the property from sparks, it did not consider risk management in preventing injury to them from burns or carrying the coal. One person also injected insulin and this information was not present on any risk assessments to protect both the person and any staff members. We also found that risk assessments were not reviewed regularly. For example, one person had the same risk assessment in place and it had not been reviewed regularly. In summary, the provider had not ensured that all risk assessments were fully completed, in place and regularly reviewed to protect people and the staff working with them.

These were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people and relatives we spoke with told us they were pleased with the service they received from staff. People told us they felt safe with the carer staff and confident that they knew what they were doing. They also told us that they thought their belongings were safe when staff came to support them and had no concerns about this. Comments from people included, "They [care staff] call twice a day and I feel happy and safe with them; they are very well trained"; "They [care staff] are great, no problems at all, they are like an extended family"; "I have been with this company for over a year. Do I feel safe with these carers? - Very much so" and "I feel comfortable and safe with them [care staff], we get on very well."

The provider had safeguarding procedures in place. The registered manager was able to explain the process they would follow, including reporting concerns to the local authority safeguarding team or the person's care manager and also to the Care Quality Commission. Where there had been safeguarding concerns, these had been dealt with appropriately by the registered manager. Staff confirmed they had received training in safeguarding and this was updated on a regular basis. This meant that people were protected by staff who knew their safeguarding and whistleblowing responsibilities and knew what they should do.

The service was one of the local authority's preferred providers and because of this, the number of people they support has increased. People we spoke with told us that there seemed to be enough staff and they were mostly on time, with the odd occasion of being late. Comments included, "We receive a regular weekly rota and they [care staff] come when they say they will"; "Their time keeping is excellent, if there is a problem they will ring and let us know" and "I receive a weekly rota of staff names and times. The schedule works extremely well, it's an exception if they make changes to the rota." One relative commented that care staff were not often late.

When we spoke to staff the comments regarding staffing levels were slightly different. A member of care staff told us that because of staff vacancies and a significant delay in providing training to new staff, they were working very long hours. They said some people were working 80+ hours. We asked if they had received extra support from a manager for the long hours and we were told this hadn't been provided but would be if

they asked for it. Another member of care staff told us, "I'm working flat out. Days and nights and sometimes I do those back to back. I avoid calling the office unless I absolutely have to because they stress me out, always trying to get me to cover even more shifts." The registered manager was aware of the additional pressure of providing support to more people and was striving hard to recruit additional staff and reduce staff working hours. We did not find any person that complained they were being provided a poor service. This meant that although a number of staff were working longer hours that normal, people still received the care and support hours they were entitled to and the registered manager was working to increase staff numbers to reduce staff hours currently worked.

Staff were provided with work mobiles to keep in touch with the office and to ring ahead if they were delayed. We were also informed that these phones were used as a safety measure in case of emergency and the need to contact emergency services was required. We also noted that the provider had issued staff with personal safety alarms and they had on call emergency numbers for staff to call, should they need additional help.

Recruitment procedures were robust. We found appropriate checks had been undertaken to ensure staff were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Staff records confirmed potential employees had to complete an application form from which their employment history had been checked. Suitable references had been provided and taken up in order to confirm this. Eligibility checks had been carried out and proof of identification had been provided.

The people and the relatives that we spoke with told us that care staff always arrived in the correct uniform and that they had no concerns about their hygiene practices as they always used gloves and wore aprons, when necessary.

Requires Improvement

Is the service effective?

Our findings

People spoken with said they were 'more than happy' with the service they received. One person told us, "The care is really good. My carer is splendid." Another person told us, "The female carers are very good, but I get on so well with the male carer he is just exceptional." People told us they had regular contact with the service and if the care staff were going to be late they would let them know. One relative told us (about their family member), "Enjoys a good natter with them [care staff], they keep her up to date with things." A further person told us, "I am very satisfied with the delivery of my requirements. If my needs increase in the future, I will definitely be looking to Helping Hands to accommodate those needs."

Staff told us the communication between themselves and the management of the service was good. One care staff member said, "We see [team manager's name] regularly. She is lovely and we can speak with her about anything." Another member of care staff said, "We are a good team and speak to each other. If there is a problem, we work it out."

Staff had support sessions which involved meeting with their manager both on an informal and formal basis. These sessions provided care staff with opportunities to discuss areas linked to their role, responsibilities and training and development needs. The service aimed to plan support sessions every three months and tried to incorporate opportunities to meet in a variety of ways, which included meeting within a group setting and having an opportunity for an annual review. The annual review provided staff with an opportunity to reflect on their performance and learning and to plan for future learning. This included support with their ongoing development. Records relating to support sessions showed a variance in relation to the number of reviews being provided for all care staff. Some staff had received one support session whilst other care staff had received two or three support sessions over the period of one year. Staff said they felt well supported in their roles and that they were provided regular opportunities to meet with managers either face to face or by using the telephone. One member of care staff said, "I am well supported in my role, there is always someone to contact should I need any guidance or support."

We recommend that the provider follows best practice and company policy in relation to supporting staff with their overall supervision needs.

The organisation had an induction programme which included the review of operational policies and procedures such as, the care of pressure care, confidentiality, and record keeping. Staff said "The induction is brilliant; I have never had an induction like this. I feel well prepared to do my job." The review of policies and procedures during the induction process supported staff to have a clear understanding of what to do in their day to day roles. Staff were provided with copies of some operational policies and procedures as part of the induction process, so they had them to refer to if they needed.

The induction programme covered awareness raising, training and competence assessments linked to moving and handling, safeguarding, care planning, infection control, first aid, food hygiene, fire awareness, medicines and dementia. The service is currently developing a new induction programme to ensure it meets with the new Care Certificate. The Care Certificate was introduced on 1 April 2015 as a framework of good

practice and is a set of standards that social care and health workers adhere to in their daily working life.

Staff were provided with a variety of training including specialist areas linked to supporting people with their specific health needs. This training was not part of the organisational training plan and was provided to care staff when required. The service had recently appointed a Clinical Advisor who had responsibility for providing training, support and advice around people's specific health care needs. Staff told us they had up to date training in safeguarding, first aid, moving and handling and infection protection and control procedures. One member of care staff told us a manager completed unannounced spot-checks on them every three weeks and said they found this very useful to make sure they were providing appropriate care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although staff were not provided with formal training relating to the mental capacity we did note that the induction process provided an overview to the Mental Capacity Act 2005 (MCA) and human rights legislation, with some awareness linked to the responsibilities of care staff.

Staff said they always ask people's consent before carrying out any activity that related to their care and support. One person who used the service said, "The carers always ask me what I would like them to do." The service did not routinely assess people's capacity to consent and make decisions. The registered manager said that people's capacity was usually assessed by the person's care manager, with information relating to any concerns being shared at the point of requesting a service. Care planning and assessment information, from the person's care manager was made available. However, there was no detail within people's care planning information about what that meant for care staff and how care staff would need to support people with decision making. In the care planning process, we did not see any routine means of recording Court of Protection orders or lasting power of attorney details, which meant that staff could not confirm if the person had these in place. This meant that staff could not be sure that any decisions made were in people's best interests and in the correct legal context because they did not have full information about any restrictions or legal processes in place.

We were, however, able to see examples where staff had contacted relatives or care managers when a decision needed to be made. Therefore, we were satisfied that the provider was aware of, and carried out their legal obligations under the MCA.

We recommend that the provider uses best practice guidelines to follow the MCA, including the recording in people's care records of relevant detailed information.

The organisation would refer to the Court of Protection with any concerns relating to a person's capacity/consent in order to keep them safe from harm. The organisation had not been required to make any referrals to the Court of Protection.

Staff told us about the links they have with medical professionals to support and promote people's health and wellbeing. One person told us, "She [care staff name] arranged a GP appointment for me. They were very good." They continued, "I get confused with numbers sometimes and they keep me right." Staff told us what they would do if a person needed to access health care services and, specialist services in relation to nutrition, for example. Another person told us, "They always notice when there is a difference in my health. They call at the chemist and collect my prescription and they cook anything I want for my meals."

The service was involved with supporting a number of people with their meals and on occasion's people needed support to eat their meals. Staff were able to tell us what they would do if a person was not eating and how they would monitor this. Care planning and assessment information did contain some basic information linked to support being provided at meal times; however, there was no process to check people's progress. The service received information from other healthcare professionals related to people's nutritional needs; however, this information was not always included within the individual's care planning review process. We spoke with the registered manager about this and we noted that the service was in the process of further developing the care planning and assessment process to ensure that all information was included.

Good

Is the service caring?

Our findings

In all cases people and relatives were positive about the service and we were told care staff were friendly, caring and approachable. Comments included, "The girls [care staff] have been very good to me, even giving me a hug sometimes"; "I have used them for more than a year; they are very good, always polite"; "They show an interest in me, they really understand what I need. I feel very safe and comfortable with them"; "I am very very lucky to have such good help, everyone is so kind" and "They are very understanding. I normally get one regular carer, she always has time to talk to me."

One relative said, "All of the carers have been really, really nice." Another relative said, "They [care staff] all love their job. They're all enthusiastic and very dedicated." We saw many compliment cards, all of which thanked the care staff and management teams for their care and commitment to looking after either themselves or a family member.

The registered manager told us they were dedicated to providing quality care to local people and said, "I want staff that go that extra mile. I want them to see to what people want done, like empty a bin or hang some washing out. I believe we have staff like that here." The registered manager had an article printed in the local newspaper in December 2015, thanking his staff for all the work they had done over the period of extremely poor weather conditions. When we mentioned this to one person, they said, "Oh the weather was terrible. Those poor lasses. They still came to see me though, God bless them."

Through conversations we had with the registered manager, and other staff within the management team, it was apparent that the caring attitude of care staff was replicated. We overheard a conversation that the registered manager had with one relative in which they showed empathy and consideration in trying to resolve the call. The call was in relation to some changes the relative wanted to make to the support their family member received. From what we heard, the registered manager resolved the issue to the satisfaction of the caller and immediately relayed what needed to happen to other senior staff.

The provider ensured that people never received support from unknown care staff, as they were shadowed by familiar care staff during their first visit. Only in emergencies would this differ. A number of people we spoke with confirmed this. One person told us, "They never just send a new carer, they always come with a regular carer first." People told us that they had good relationships with the staff team and, in many cases, this had evolved over many years of support.

All people and their relatives that we spoke with were aware of their care plans and said that it was reviewed regularly with them involved at all times. One person said, "Manager calls regularly to talk to me about the care plan." Another person told us, "Someone from the office reviews my care plan. They make an appointment and come to the house to talk to me about it." People and their relatives confirmed they received enough information from the service and we saw that they had access to a service user guide which the provider had given out to people and their families.

Staff were respectful and treated people with dignity. One person told us they are very respectful towards

them and continued, "It's a difficult job; they [staff] do it very well." A relative said, "They are very respectful towards my wife, they talk a lot with her, she enjoys their company." Another person said, "The girls [staff] always respect me. It could be very embarrassing to have other people wash you, you know. These girls are great though – there is no embarrassment as they make you feel at ease." At the time of writing this report, a concern had been received from one particular family in connection with respect and dignity and this was being investigated by the local authority safeguarding team. The staff members we spoke with understood the need to protect people's privacy and to keep people's personal information confidential.

People confirmed that staff helped them to remain independent in a number of ways and gave lots of examples. One person told us that staff encouraged them to make their own meals with staff support. Another person told us that staff helped them to continue to get out into the community and meet friends. One person said, "I think they encourage me to maintain as much independence as I can."

From records we checked, we did not see any evidence of people using advocates, as the majority had relatives to support them and no issues had arisen to require this level of support. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. We spoke with staff about the use of advocacy services and they told us that if people needed that level of support and help they would help them source it.

Requires Improvement

Is the service responsive?

Our findings

Before people took up the service a referral form was usually completed with information about the person. This form gathered general information, including various contact details, a brief history of the person and any special requirements. Once a person had been initially screened then a plan of care was drawn up. People's records included information on their care preferences, likes and dislikes. People had their social history documented to help staff provide suitable care. This information had been completed with people and their relatives. For example, one person had told staff they did not like to be patronised and also found being assisted to mobilise very unnerving. We saw staff had explored and documented strategies to make sure they met these needs. One person we spoke with said, "I've been involved in my own care planning since we started getting help from the provider and they often show me my daily notes and assessments."

However, people's care records were not always up to date or fully completed. For example, one person's care plan was based on out of date information from healthcare professionals and stated they lived alone, which increased the level of their assessed risk. However, this person lived with a relative and received care from them. Another record did not match with the information staff had written on the daily care notes. Staff had indicated that the person was at risk of falls and had supported them, yet the care records showed no evidence of this being assessed as a need that the person required support with. We found examples of six monthly reviews which had not been completed and some of those that were completed contained limited information. One record we found had not been reviewed for over 2 years. We spoke with the registered manager about what we had found and he told us that they were starting to use new 'service user preference and care plans' and more training was being completed. We confirmed that some of the missing information was on the new format. Overall, it was not clear from the records we saw that the provider had fully assessed, planned and reviewed people's care and support needs. This meant that people may not have received appropriate care to meet their changing needs.

These were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People thought the care staff responded well to any requests or changes they needed to make. One person told us, "The carer sorted out the problem with my TV; she popped some washing in for me. They do anything I ask of them." A relative said the provider had been very flexible with care visit times over the Christmas period. They said they had been offered the chance to change regular care times to fit in with family arrangements. One person told us, "They are very well organised, I really like the company." Another person said, "Just last week my care plan was reviewed with me and we talked about finance and equipment as well."

To help people avoid social isolation care staff provided people with information on what was happening in the local area and the provider had set up support groups within local communities for people to attend. The registered manager told us that at these groups various fundraising and other activities took place, to support the people attending and to help various groups and the local community. People's comments included, "They are local carers, so they are able to hold conversations of what goes on in the area. They

keep me up to date with what is happening"; "They listen to me and they respond to what I say. I see them daily and it's a good opportunity for a chat" and "They have long conversations with my wife while they work and they make her laugh."

People told us they had choice. One person said, "The carer will do things the way I want them done." The service included enabling as part of a care package. We were told by care staff that one person liked to go to a garden centre and another liked to go and buy particular food on a certain day during the week. Another person told us, "I choose what I want and when I want it. They [care staff] don't force me to do anything I don't want." This meant that people had the choice to do what they wanted, when they wanted.

People had a copy of the complaints procedure in their homes and told us they knew what the policy was and how they would use it. One person said they didn't know they had a copy but they knew the manager and would call them if there was a problem. This documentation included contact details for the provider, including details for out of hours emergencies. One person who had complained in the last year told us, "They responded very well to my complaint, the manager comes out to see me if there is a problem." Another person, who had made a minor complaint, told us that one of the management team came to visit them and sorted the issue out immediately. They said they were very satisfied. When we looked at letters in the complaints file, the majority of responses from the registered manager started with an apology for delays in responding. It was very difficult to check how delayed the responses were, as the file did not contain the original complaints. In some instances the complaint letter was available but there was no record of the response. When we asked the registered manager if there was an auditable trail of complaints he said there was not. It was not clear if complaints came in to a single point of contact, who investigated, how a resolution was reached or if the promises of the complaints policy were upheld. This meant it was not clear if complaints had been dealt effectively and in line with best practice or the company's own complaints policy.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place who had worked for the organisation since 1993 and was also registered as the nominated individual. They told us they were dedicated to providing people with good care. We had a conversation with the registered manager about the shortfalls we had found during the inspection. He told us he was aware of the work that needed to be done and that they needed to "pull their socks up". We explained that although we had found no evidence to show that people had come to any harm, there was evidence to show certain areas around record keeping and governance, in particular, needed to be improved.

There had been an accident involving a person which had injured a staff member. The accident should have been raised as a safeguarding notification to the Commission. However, when we checked our records we found no information had been sent in relation to this incident. We also found a number of safeguarding concerns which had not been notified to the Commission, in line with legislation. We contacted the local authority safeguarding team and asked for information about the number of incidents which had been reported to them. When they responded, we found that the information did not match with our records. After the inspection, we asked the provider to send us information about safeguarding incidents since our last inspection. The information which was returned did not match with our records. It is a legal requirement that the provider sends notifications to the CQC as part of their registration. Notifications are incidents that occur at the service. For example, incidents of a safeguarding nature, serious accidents or deaths. The provider had failed to do this.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager stated that they had never audited or checked any records of accidents or incidents. When initially asked about the service's IT systems, he told us there was no way to check for any accidents or incidents on the system. However later in the day he was able to show us accidents and incidents that had been recorded on the service's IT system. This meant systems were available to support the checking or auditing of accidents and incidents, but they were not used.

Office staff and the registered manager admitted that people's records were never checked or audited. People received a review every six to eight weeks into their care package with six monthly checks thereafter. Notes were removed in an ad hoc manner from people's homes and returned to the office. These where then put a plastic wallet and then into a filing cabinet drawer (in a pile, not filed). When the filing cabinet drawer was full, the plastic wallets were put in a box and taken to a different office. This meant that an individual could have several wallets of records in multiple boxes. None of these notes were checked or audited. We looked at these records, and found inappropriate comments about poor practice in notes. For example, one member of care staff had written in a person's daily notes, "Night bag had not been attached - woops - sorry." Another member of care staff had written LOL against one entry, while another member of care staff explained that a person had a 'sarny and biscuit for lunch. Sarny was likely to mean sandwich and LOL was likely to mean laugh out loud or lots of love. We also found many examples of writing that had been scribbled out and replaced, including missing sections of recorded paperwork. One entry included

information about the person being taken to hospital, but we could find no further entries about what happened to that person in either hard copy care records or on electronic information. We showed the registered manager what we had found and he agreed that this was not appropriate and said staff should know better.

We checked with the office staff. who indicated that none of the records were locked away out of office hours, although they were in filling cabinets which could be locked. In addition, they confirmed that confidential records were left out in the general office. This is in clear contradiction of the provider's data protection policy. None of the staff we spoke with were aware of how long old records should be kept. One staff member said, "Don't worry, no-one could find anything because it's filed all over." They continued, "The notes of deceased clients are kept under [staff members] desk in a box." Confidential information, such as complaints and safeguarding reports were kept in an arch lever file on a shelf in the general office.

In the policy file we were able to see that the newest policies and procedures were dated 2010. Some of the wording was out of date and therefore misleading. Many of the policies, such as manual handling, should be regularly updated to comply with legislation. There was also no specific policy for infection control. We saw that the manual handling policy had not been reviewed in light of recent manual handling incidents in the service. There was also a safeguarding policy available and this too required updating as there was a suggestion that staff would hold on to information and review it within the company delaying handing it over to the appropriate authority. We also noted that the statement of purpose which we were given by the registered manager was dated October 2012 and this included many pieces of outdated information. When we looked at the provider's website, we found a 'service user guide' dated 'Feb 04' which also contained out of date information. For example, the name, address and details of the Care Quality Commission.

These were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had the impression that the service was well led from the contact they had with team managers and often from the registered manager, if he needed to contact them. One person said, "The company seems to be very well managed, we get a rota each week and it's usually spot on with who comes." Another person said, "I think they must be well managed, we don't have any problems." A member of care staff said, "There's good support for us from the office. Most of the managers used to be carers themselves so they understand the job very well." Team managers were the direct line managers for the majority of care staff and all of the comments we had about the staff in these roles were positive.

Staff told us that team meetings took place every few months. They told us the meetings were general and a chance to share information. Although one staff member told us they felt they did not learn anything; that was not the reflection of the team as a whole. We attended a team meeting in the community with eighteen members of care staff. We saw that staff had the opportunity to discuss items that were important to them and general support was offered. One care worker said, "Our manager is lovely, she always listens to us and you can go to her with anything." This meant that the staff team were supported as a group to discuss various items and gain mutual support from each other.

The provider sent out a newsletter to the whole staff team every month. Information included various sections from advice about health and safety, holiday information, staff birthdays or other anniversaries and a section called '[registered manager's name] blog. This blog, included reminders to staff about (for example), mobile phone usage, vacancies and any thank you's or updates. One member of staff told us, "It's a good way to update the staff team."

Part of the organisation's mission statement and values is in "meeting the needs of the people who use the service and are willing to adapt their practice any way they can to empower those who by nature of age, illness or disability have difficulty with routine activities of daily life". Although we found that paperwork in general required improvement, we also found that in general, staff maintained the organisations values which were dedicated to efficiency, quality and customer satisfaction.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system for identifying, receiving, recording, handling and responding to complaints was not in place. 16 (1) (2)

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected because the provider had not always assessed and mitigated against risk. Accidents were not always recorded or monitored fully and risk assessments were not always completed or reviewed. Medicines were not always managed safely and in line with good practice. 12 (1) (2)(a)(b)(g)

The enforcement action we took:

We used our enforcement powers in respect of this breach.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no quality assurance system in place to monitor the service provided to the people receiving it, this included monitoring risk and ensuring policies and procedures were up to date. The provider did not always maintain up to date records for people or keep them secure at all times and failed to check that records were completed appropriately by staff. 17 (1) (2)(a)(b)(c)(d)(f)

The enforcement action we took:

We used our enforcement powers in respect of this breach.