Altonian Care Ltd

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Inspection report

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Date of inspection visit:
29 February 2016
01 March 2016

Date of publication:
11 April 2016

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?	Inadequate

Summary of findings

Overall summary

The inspection took place on 29 February and 1 March 2016 and was announced to ensure staff we needed to speak with were available. Altonian Care Ltd is registered to provide personal care to older people and those living with dementia. They also provide a service to people with a physical disability, sensory Impairment and younger adults. At the time of the inspection there were 60 people using the service.

The service has a registered manager who is also the provider; they work within the service managing it on a daily basis. 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.

Medicine audits were not effective and MARs had either not been audited or contained gaps that had not been identified or addressed, this had placed people at risk of unsafe medicines administration.

There was a lack of robust systems to assess the quality of the service people received and to identify any potential risks to people. Information generated from incidents, care calls and staff training and staff supervisions for example, had not been used to monitor the quality of the service people received or to identify any trends in relation to people's care to ensure their safety.

Accurate and complete records were not always maintained. People's views on the service had been sought however there was a lack of evidence to demonstrate feedback had been used to drive service improvement.

The provider had not ensured that when staff joined the service from other providers that they had obtained written evidence of their medicines training prior to them being rostered to administer people's medicines. There was a lack of evidence to demonstrate staff's competency had been assessed following medicines training. People's MARs were hand written and not checked for errors. Although there was no evidence that people had come to harm, people had been placed at potential risk of harm from unsafe medicines administration.

Records showed not all staff had completed training in areas such as safeguarding, Mental Capacity Act (MCA), and moving and handling. Staff had been rostered to support people with moving and handling without written evidence of their qualifications and competence to do so. Although there was no evidence that people had come to harm, people had been placed at potential risk of harm from unsafe or ineffective care.

People provided positive feedback about staffing. They told us they received consistency in their care and that staff stayed the required length of time. The provider did not have a formalised system to plan for their staffing needs, but they understood staffs availability and the capacity of the service to take on new

packages of care. The provider had not ensured they had monitored the duration of people's calls, to ensure they received calls of the required length. The provider had completed relevant pre-employment checks upon staff to ensure their suitability to work with people.

Staff told us they felt supported by the provider in their role. Staff records demonstrated staff had received some one to one supervisions and spot checks of their work. However, as the provider did not keep a central record of these, there was a lack of written evidence to demonstrate that staff were sufficiently supported, to ensure they could support people effectively.

People told us that they felt safe from abuse or harm. Staff told us that they knew what to do if they suspected that someone was being abused or was at risk of harm. The provider did not have a robust system in place for recording their management of safeguarding concerns, to demonstrate the actions they took and to be able to demonstrate people were adequately safeguarded.

People had risk assessments in place which identified risks to them personally and from their environment and the measures required to ensure they were managed safely for them.

People told us staff sought their consent before they provided their care. The provider was able to give an example of a MCA assessment they had completed for a person, who lacked the capacity to make a particular decision themselves. However there was a lack of written records to demonstrate how this decision had been reached. We have made a recommendation that the provider seeks further guidance on the MCA in relation to the recording of assessments.

People's care plans documented their food preferences. Risks to people in relation to eating and drinking had been assessed and measures taken to mitigate them, for example, by recording their food and fluid intake. Improvements could be made to these records to ensure they were fully effective. Staff had guidance about what support people needed to eat and drink. People were adequately supported by staff to eat and drink sufficient for their needs.

People's records provided details of relevant health care professionals. Records demonstrated staff had contacted people's GP or district nurses where required. They had also supported people to attend healthcare appointments. People were supported to maintain good health.

People told us that they were treated with kindness and compassion by their care workers.
People's daily routines were documented in their care plans to ensure staff were aware of people's preferences. Staff involved people in making decisions about their care. People's communication needs were noted in their care plans. However there was not always clear written guidance for staff about how they should support people in relation to this need. People experienced positive relationships with staff.

People's privacy and dignity were respected and promoted. Although on rare occasions we observed staff could have improved their practice in relation to how they upheld people's privacy and dignity. However, this was not reflective of the service as a whole. People's privacy and dignity were maintained.

People told us that the service was responsive to changes in their needs. People's needs had been assessed prior to them receiving a service. The provider had been responsive to changes in people's care needs.

The provider had used different documentation to document people's care needs and this had led to variability in the content of people's care records. Some care records contained a greater amount of information and guidance for staff than others. Although there was written guidance for staff in the event

people's behaviours challenged them there was no guidance for them about what to do if a person with diabetes required support during a call. Although people told us staff knew the actions to take, this was not actually documented to ensure staff unfamiliar with the care of such persons had access to relevant guidance.

The provider told us people's care was reviewed with them on a three monthly basis. However, there was a lack of written evidence to demonstrate people's reviews of their care by the provider had always taken place as frequently as required.

People told us they had not needed to complain but felt they could do so if needed. The provider ensured people had access to information about how to complain.

People felt that management had insufficient time to manage the service and were not sufficiently organised. Staff told us they felt well supported by management. The provider was heavily involved in the delivery of the service as were other office staff. This left insufficient time for them to focus on overseeing and leading the service. People's care had been impacted upon negatively by the lack of leadership as demonstrated by the issues identified during the inspection.

People told us they had observed a positive culture overall amongst the staff. The provider had a set of values for staff to apply in their work with people, which staff understood. The provider had not consistently upheld their own values in relation to ensuring people's safety or the quality of service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the 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.

There were not robust checks in place to ensure all staff had undertaken medicines training and were competent to administer people's medicines safely. Although there was no evidence to demonstrate people had experienced harm as a result, people's medicines were not managed safely.

The provider had ensured there were sufficient staff to provide people's care. Relevant pre-employment checks had been completed to ensure staff were suitable to work with people.

There were not clear processes in place to ensure staff fully documented when they reported safeguarding concerns, to ensure there was sufficient documentation to enable the provider to be able to demonstrate the actions they had taken to safeguard people.

Risks to individuals and the service were generally identified and sufficiently managed.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of written evidence to demonstrate all staff had undertaken relevant training and had their competence assessed in relevant areas such as moving and handling, prior to providing people's care.

Staff had received some supervision and reported that they felt supported in their role. There was a lack of a process to monitor staff were receiving sufficient supervision to ensure they could support people effectively.

People's consent had been sought. Where people lacked the capacity to make a specific decision legal requirements had been met, but good practice had not been followed in relation to the recording of such decisions.

People were supported by staff to eat and drink sufficiently

although fluid records charts could be improved for people.

People were supported to maintain good health.

Is the service caring?

Good

The service was caring.

People told us that they were treated with kindness and compassion by their care workers.

Staff were aware of people's likes and dislikes and took these into account in the provision of their care. Staff involved people in making decisions about their care.

People told us staff upheld their privacy and dignity in the provision of their care. On rare occasions we observed staff could have improved their practice in relation to how they upheld people's privacy and dignity. However, this was not reflective of the service as a whole.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always consistently receive personalised care that was responsive to their needs. There was variability in the content of people's care records to ensure staff had access to all relevant information about people's needs.

People were provided with information about how to make a complaint if required.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that quality was integral to the service provided. There were not robust systems in place to monitor the quality of the service. Records were not always accurate or complete. There was a lack of evidence to demonstrate people's feedback had been used to improve the quality of the service people received.

The service was not well led or well managed. The provider was heavily involved in the delivery of the service rather than leading and overseeing it.

There was a positive culture amongst the staff. However, the

provider had not consistently upheld their own values in relation to ensuring people's safety or the quality of service.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 February 2016 and 1 March 2016 and was announced to ensure staff we needed to speak with would be available. The inspection team included three inspectors.

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 the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we sent 50 questionnaires to people who use the service to seek their views and 17 were returned. We sent 39 questionnaires to staff and 11 were returned, 50 questionnaires were sent to people's friends and relatives, of which three were returned and one questionnaire to a community professional which was not returned. We also spoke with a commissioner of the service who told us they had received positive feedback from people about the service they received.

During the inspection we spoke with 10 people and eight people's relatives. As part of the inspection we also visited three people at home with care staff. We spoke with the provider who was also the registered manager, three office staff and five care staff.

We reviewed records which included 14 people's care plans, four staff recruitment and supervision records and records relating to the management of the service.

The service had not previously been inspected.

Requires Improvement

Is the service safe?

Our findings

There was a lack of written evidence to demonstrate that 12 care staff had undertaken medicines training. The provider told us eight of these staff had transferred from other domiciliary providers where they had completed this training. However, the provider had not obtained written evidence of their training or when they had completed it, to ensure it was current. There was evidence that eight of the 12 staff had been rostered to provide care to people who required support with their medicines. Although there was no evidence people had experienced any harm as a result. People's medicines had been administered by staff for whom there was no evidence of their up to date medicines training which had placed people at risk of receiving unsafe care.

The provider told us once staff had undertaken medicines training their competency was assessed; however, there was a lack of written records to evidence these checks. People had been placed at risk of harm of receiving their medicines unsafely, as there was a lack of records to demonstrate staff competence in the safe administration of medicines.

The provider told us people's medicine administration records (MAR) were hand written. A staff member had incorrectly spelt a medicine on a MAR. As MARs were not being checked by a second member of staff as required by the provider's medicines policy there was no process to identify this error. This placed people at potential risk from unsafe medicines administration.

People's care plans lacked reference to a medication list to enable staff to check whether the pharmacist had dispensed the correct medicines to the person or whether the medicines were to be administered from a dosage system. People were placed at risk of receiving their medicines unsafely due to a lack of written guidance.

The provider had a medicines policy which they had purchased from an external company and which had not been individualised to the needs of the service. For example, some of the guidance did not reflect that staff were providing a service to people in their own home and not in residential care. There was no evidence to demonstrate staff had read and understood the medicines policy. People were placed at risk from the unsafe administration of medicines as the medicines policy did not reflect the service provided and staff were not required to read it.

The provider's failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people who responded to our questionnaire about staffing was positive. 94% told us 'I receive care and support from familiar, consistent care and support workers' and 'My care and support workers stay for the agreed length of time.' People told us staff provided their care at the time they wanted and stayed for the required time. People said they had consistency in the care staff providing their care, which records confirmed. A person told us they always liked to meet new care staff before they provided their care so the provider ensured they were introduced to them before they were rostered.

The provider told us they did not have a system to plan for their staffing needs. Instead they had a list which identified where staff had availability to attend new care calls. They told us they currently had two vacancies for care staff and one for office staff. They took this into account when determining whether they could commit to the provision of care for new people. The provider understood their staffing availability and capacity to take on new calls for people.

The provider told us that they had a 'Login system in place' for staff to use when they visited people to enable them to monitor the length of visits. However, not all staff actually used it and therefore they were not able to provide any written evidence to demonstrate whether all staff had stayed for the complete length of the scheduled visits. People spoken with seemed satisfied that their visits were of the required duration but there was a lack of written evidence to demonstrate this. The provider had not ensured they had monitored the duration of people's calls to ensure people received the correct length of call. Instead they had relied on people to inform them of any issues.

Staff recruitment records included applications forms which explained any gaps in employment history, some interview records, references and evidence of Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. People were kept safe because the provider completed relevant checks on staff before they began work.

People told us that they felt safe from abuse or harm from their care workers. One relative told us she felt that her husband was "In safe hands" with his carers.

Staff told us that they knew what to do if they suspected that someone was being abused or was at risk of harm, although records showed not all of them were up to date with their safeguarding training. Staff had access to information about safeguarding in the staff handbook and there was a standardised safeguarding policy and procedure in place. This included the contact details for the local Safeguarding Adults Team. However staff were not expected to read the policy, or to sign to say that they had read and understood it. The provider instead relied on the staff handbook and the safeguarding training to inform staff of their safeguarding duties. Risks to people from financial abuse had been identified and assessed in their care plans. This ensured that staff were aware of anyone who was particularly vulnerable to this type of abuse. Staff did not always follow correct procedures, such as filling out an incident form when they identified a potential safeguarding concern. Therefore although the provider had taken the correct action when concerns were raised and liaised with relevant authorities, they did not always have a written incident form for the event, or of the action they had taken in response to it. The provider did not have a clear system to ensure staff completed an incident form for any safeguarding concerns, to demonstrate how people had been safeguarded.

A relative told us that she felt that any risks to her loved one were effectively managed. Documentation identified people's medical history to ensure staff were aware of any relevant information. People's allergies had been documented in their care plans. Risks to people in relation to the development of pressure ulcers were identified within their risk assessments. This included any action required to manage this risk to people, for example, through the use of preventative creams, and to report any concerns to the office. The risks to people from unsafe water temperatures when bathing had been assessed and managed safely. One person was at risk of wearing the same clothing if not prompted and their care plan advised staff about how to manage this risk to them.

People had a moving and handling assessment to identify their needs in relation to transferring them safely, including the number of staff needed, any equipment required and any other factors such as medication

that could affect their mobility. People's moving and handling assessment noted if they were at risk from bruising and documented if the person had a history of falling. Risks to people had been identified and guidance was in place for staff to manage them.

Risks to people from their environment had also been assessed through a health and safety assessment. This considered the risks to people from their environment, infection control, food hygiene, chemicals, fire, water, gas and electricity. People's care plans contained details of the arrangements to access their accommodation, for example by the use of a key safe. There were also assessments of the risks to staff around lone working, accessing properties and consideration of contingency arrangements for emergencies and bad weather. The provider told us there was an out of hours number to ensure people and staff could access assistance if required. The provider had ensured risks to people and staff had been assessed and managed safely.

Requires Improvement

Is the service effective?

Our findings

People and their relatives feedback about staff knowledge and skills was positive overall. Most felt that staff were sufficiently skilled to carry out their role.

The Care Certificate is the industry standard induction for staff who are new to care. The provider told us and records confirmed that some but not all staff who were new to care had completed this training on-line. There was a lack of written evidence to demonstrate that staff competence had been assessed and recorded as required, as part of their award. Staff were not able to demonstrate that they had fully met the requirements of the Care Certificate in relation to their competency, to ensure people received safe and effective care.

The provider was unable to tell us at the start of the inspection what their mandatory training was or how often they required staff to update it. During the course of the inspection they decided that moving and handling, medication, infection control, safeguarding and mental capacity were mandatory. However, this meant staff were not required to update their training in other areas included in the Care Certificate such as basic life support and health and safety. There was a lack of evidence to demonstrate how the provider would ensure staff would remain competent in these areas to ensure they could continue to provide people's care safely.

Of the 44 staff, 15 had no written evidence of them having undertaken infection control training, 10had no written evidence of their safeguarding training and 20 had no written evidence of training in the Mental Capacity Act 2005. Thirteen staff had no written evidence to demonstrate they had completed moving and handling training. The provider told us some of these staff had completed these courses in their previous employment. However, they were not able to provide any written evidence of this or that their training remained current. Although there was no evidence people had experienced any harm as a result the provider had not protected people from the risks of unsafe care as by ensuring all staff had either undertaken relevant training or been required to provide written evidence of their completed training.

The provider told us staff underwent on-line moving and handling training. They said staff competence was then assessed, but they were unable to provide written records to demonstrate these assessments had always taken place. Staff had been rostered to move and transfer people who required this support without the provider having assured themselves of their qualifications and competence to do so. As a result people had been placed at potential risk of harm from poor moving and handling practices.

The provider's failure to ensure staff providing people's care had the qualifications and competence to do so was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's handbook indicated staff supervision should take place every three months and spot checks every three months. Not all staff records reviewed demonstrated that they had received one to one supervision or spot checks. Staff told us they had received supervision and felt supported in their role by the

provider. However, as there was no central record of staff supervisions, there was a lack of evidence to demonstrate staff supervision and spot checks were taking place as frequently as required by the provider to ensure people received effective 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us staff sought their consent before they provided their care. The provider had a form for people to sign to demonstrate their involvement in their care plan and agreement to the care to be provided. There was evidence that some people had signed their consent although this had not been recorded consistently, so there was not always written evidence of their consent.

Staff spoken with about the MCA understood the principles. However, there was a lack of evidence to demonstrate all staff had undertaken relevant training. People's care plans sometimes documented that they had the capacity to make decisions about their care to ensure staff were aware of this information. The provider had noted if people had an Enduring Power of Attorney, this ensured staff knew who they were legally obliged to consult in the event the person lacked the capacity to make a specific decision. The provider told us of a situation where a person lacked the capacity to make a decision about their care and how they had liaised with the relevant parties to ensure a decision was made in their best interests. There was however a lack of written evidence to document the assessment and how the decision had been reached. It is good practice to document such decisions to ensure there is written evidence to demonstrate legal requirements have been met.

People's care plans documented their food preferences for example their preferences for breakfast. People's records included an assessment of whether they were at risk of choking when eating or drinking and the actions staff should take to ensure their safety. Their care plans provided staff with guidance about whether people required their meal to be cut up for them and the support they required from staff to eat their meal. Staff had guidance about any equipment people required to enable them to eat and drink.

Staff completed food and fluid charts for people where required if they had been identified as at risk from malnutrition or dehydration, to ensure there was a record of their intake. People's fluid charts did not document how much fluid staff should be aiming to offer the person per day or provide a total for their intake to enable effective monitoring of the adequacy of people's intake. Therefore people might not have been supported by staff to drink sufficient during the day.

People's care plans provided details of their GP to ensure staff knew who to contact about any issues in relation to their health. Records demonstrated people had seen relevant health care professionals where required for example, GP's district nurses, occupational therapists. Where people were receiving support from health care professionals for example in relation to the management of their diabetes this was documented in their care records. The provider told us they supported people to attend health care appointments where required, this was confirmed by records. People were supported to maintain good health.

We recommend the provider reviews the Mental Capacity Act Code of Practice 2005 in relation to good practice for the recording of mental capacity assessments and best interest decisions for people.

Good

Is the service caring?

Our findings

People told us that they were treated with kindness and compassion by staff. Most people told us that they were introduced to staff before they provided care and support and the provider told us that wherever possible, staff did the same rounds to enable them to get to know the people they were supporting. Many of the people we spoke to also confirmed this. We were told by people that their staff were "Delightful", "They are my rocks" and "They know exactly what I want." One person told us that they "Can't fault any of the staff", that they are "The best ever" and even feed the birds for them. The majority of people we spoke to described staff as warm, caring and kind. One person told us they received "Excellent care – and this is not a word you can use very often. I don't think I would survive if it wasn't for them." Another told us that "There is not one who is not cheerful and helpful" and that staff "Are more like friends than carers." A relative told us that the staff are friendly and make their loved one laugh, and another told us "They always chirp him up." They described staff as approachable and helpful and would always ask "Is there anything else I can do for you?"

Most of the care plans we saw captured information about people's likes and dislikes, although this was not always consistent. However, people's daily routines were usually detailed in care plans, such as what activities they liked to do and what time they got up and went to bed. People's care plans provided staff with guidance about how they were to ensure people's comfort. For example, one person's care plan said they liked to be left with their rug over their feet. There was information about what people liked to do throughout the day, for example one care plan noted that the person 'Likes to have their tea and then watch the six o'clock news.' Another care plan instructed care workers to make sure that they 'Offer a cup of tea and have a chat' with the person as they "'Like to talk." Another noted that the person 'Will never turn down a cuppa' and to 'Keep X smiling by chatting to her.' People's daily routines were documented in their care plans to ensure staff were aware of people's preferences.

Accompanying staff on their home visits, we saw examples of staff being clearly interested in, and knowing a lot about, the people they were going to support, including their likes, dislikes, behaviours and health. We observed staff being kind and jolly when delivering support, explaining to the person what they were about to do and checking they were ready. Staff talked to the person throughout the delivery of their personal care and were warm and encouraging, asking "How is that? Are you ok? How are you doing there?" And when applying creams, "Are you ready for this – it's going to be a bit cold!" There was also praise and encouragement for people "That's it, well done, perfect." People had formed positive relationships with the staff caring for them.

People's care plans provided guidance to staff to ensure they involved people in making choices about their care. For example a person's care plan told staff to ask the person what they wanted for breakfast. Their preferences about how they wanted their care to be provided were documented. Another person's care plan stated how they liked their bed to be made. People's religious beliefs were documented in their care plan and any arrangements they had in place to meet these. Staff told us how they would respect a person's right to exercise choice, independence and control, describing how they would offer meal choices and encourage people to make their own decisions about how their care was delivered, such as whether or not

they wanted a shower or what they wanted to wear. One care staff told us "It's their choice, in their own homes." One care plan noted that the person would let care staff know when they were ready for their personal care to begin and would give a little nod to indicate this. People were involved by staff in making choices about their care.

Staff were respectful of people's choices and encouraged and facilitated their choices. Accompanying staff on their visits, we heard people being offered choice over their personal care. We heard a person ask for more support with their neck which care staff responded to by adjusting their pillow and checking with them that this had made things more comfortable and whether there were any other adjustments they could make asking "Do you want this a bit higher?" and "Do you want a pillow….to make you more comfortable?" Staff also scratched the person's back for them; the exchange between them indicated that this was something which was clearly a regular request which the staff were happy to respond to. People were encouraged by staff to express their wishes.

People told us that they were treated with respect and dignity by their staff and that their privacy was upheld. Staff were able to describe to us the measures they took to uphold people's dignity. Staff were told in people's care plans to announce their arrival if they entered the property using a key to ensure the person was aware of their presence. People's care plans provided staff with written guidance about how they were to uphold people's privacy and dignity. For example, one care plan noted to ensure the person had access to their personal possessions, advised that they were able to cut up their food independently and add their own sweeteners and creams to hot drinks. One care plan detailed the order in which a person's clothes and incontinence pad should be removed in order to maintain their dignity. People's care plans also noted their preferred mode of address and staff were familiar with the names people wished to be known by. Staff had guidance about how they should uphold people's dignity.

There was a standardised privacy policy and procedure in place, although staff were not required to sign to say they had read this. The provider had not ensured there was written evidence of staff's understanding of this policy in relation to the provision of people's care.

We observed that in general, people's privacy and dignity were respected and promoted and people we spoke to agreed with this. Curtains were drawn when staff delivered personal care, and doors were closed. People's care was delivered respectfully and sensitively and we heard staff talking gently to people about what they were going to do, and making sure the person was happy. Staff described to us how they would respect people's privacy and dignity, such as ensuring that they were covered with towels when personal care was delivered to uphold the person's dignity.

We observed on two occasions that privacy and dignity were not always upheld as well as it should be, for example, doors and curtains were not properly closed at all times when supporting a person with personal care and helping a person use the toilet was not handled as sensitively as it could have been, and the person was rushed. The provider was given feedback on this observation to ensure they could address this with the staff member for the person. This incident was not reflective of the service as a whole, as people also told us that they were treated with dignity and respect by staff and that staff always took their time and did not rush people, even if they were running behind with their visit times. One person's care plan stated that that the person should be "Encouraged to take her time with her frame and not to rush." People's care overall was delivered by staff who upheld their privacy and dignity.

It was noted when speaking with staff that none of the them willingly divulged people's names and always checked with us that it was appropriate to identify the individuals they were referring to. This showed that staff were aware of the need to reflect people's right to confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Feedback from people who responded to our questionnaire about the responsiveness of the service was positive. We found 94% agreed that 'The support and care I receive helps me to be as independent as I can be' and that they were involved in decision-making about their care and support needs. People we spoke to also agreed with these comments. A person told us that their care needs had been assessed and reviewed with them and said "Staff understand the care plan." Another person's relative told us their loved one's care package had been decreased in response to the person becoming more able to manage tasks for themselves.

People's records demonstrated that their care needs had been assessed prior to them commencing the service and where relevant, copies of their social services needs assessments had been obtained, this was confirmed by people and their relatives. The provider had accessed information about people's care needs upon which to base their care plans and to ensure that their care met their identified needs.

People's care plans provided staff with guidance about what care people required to achieve their care objectives. For example, one person's care plan said they liked to do a lot for themselves and staff should assist where required. People's care plans demonstrated that where they needed to complete exercises to maintain their independence guidance was provided for staff about how to support them. However, although 90% of staff who responded to our questionnaire said 'I am told about the needs, choices and preferences of the people I provide care and support to,' there was some variability in the content of people's care plans. Different documents had been used by the provider at different times to document people's care and there was variability in the amount of detail each person's records contained. Some were much more detailed than others and provided staff with more information. Sometimes but not always there was information for staff about people's background, this ensured staff had information about the person's life history and employment which they could use to initiate conversations with them. There was a risk that staff might not always have had access to relevant information about people in order to meet their needs.

When people had been assessed as experiencing behaviours which could challenge staff their care plan contained guidance for staff about how to manage this. For example, by identifying what the behaviours were, possible triggers and strategies. Where people experienced diabetes this was also noted within their care plan. We noted, however, there was no written guidance in the event that a person experienced hypoglycaemia where their blood glucose levels fall or hyperglycaemia when their blood glucose levels rise. We were advised by one person that they did have a 'Hypo' one day and that their carer "Knew exactly what to do." Although this member of staff understood the actions they should take, written guidance would have ensured all staff could be responsive to any change in the person's presentation, knowing what action they should take.

People's records documented if they had difficulties with communication. Sometimes, but not always, there was guidance for staff about how to communicate with the person. For example, through the provision of reassurance, time and understanding. People's records documented any communication issues they experienced but did not consistently provide written guidance for staff to follow.

The provider told us senior care staff were able to update people's care plans if required using an application on their smart phones. The office staff then ensured people were sent a new copy of their care plan and that staff were alerted to relevant information. There was a process to ensure people's care plans could be updated in response to changes in their needs and for these changes to be shared with staff, which records demonstrated did take place.

The provider told us most of the care they provided to people was through packages of care commissioned by social services who determined the number of calls and the duration of the calls people required. They told us they implemented the requested package for people and then contacted the commissioners if they found people's care was taking longer than required so this could be addressed for them. The provider was aware of whether the time allocated for people was adequate for their needs and took action to address this for them if required.

We saw in people's records, that the service was responsive in ensuring that additional care was provided for people where required. For example, if their family were going away, or had medical appointments themselves, this was confirmed by relatives. The service was responsive to changes in people's needs and requests for changes to their care.

The provider told us people's care was reviewed with them on a three monthly basis or sooner if required. When people had a review this was entered onto the computer to trigger the date for their next review. There was not always clear evidence to demonstrate people's care had consistently been reviewed every three months as the provider required to ensure people's care plans remained relevant.

People told us they would be comfortable in sharing any concerns or raising any complaints and would do this by directly contacting the office. People told us they had done this in the past to advise that they did not want particular staff and that their concerns had been addressed. One person told us they would phone the provider if they had any concerns. Another person told us "I have never had any problems and would say if things weren't how I wanted them to be." A relative told us that they would go straight to the provider if they had any complaints and would have no doubt that any issues would be resolved.

People told us that they had not needed to raise a complaint, and the provider confirmed that they had not received any complaints; information about how to make a complaint was included in the service user guide and on their website to ensure people had access to relevant information.

The provider had a standardised policy and procedure on Complaints, Suggestions and Compliments in place, and the staff handbook provided staff with information about the action they should take in the event they received a complaint. There was also a compliments file kept in the office.

Inadequate

Is the service well-led?

Our findings

The provider had not ensured that there were robust systems and accurate and complete records in place to ensure people received safe and effective care, or to drive service improvement. For example, although the computerised staff rostering system could be used to ensure only suitably qualified staff were rostered for each call the provider told us they did not use this feature and calls were rostered based on staff's availability, rather than their suitability. The system to log the length of calls people received was not used by all staff and the provider told us they had not taken action to require staff to use it. Therefore they were unable to effectively monitor whether people's calls were of the required duration and relied on people reporting any concerns about the length of their calls. There was a lack of a robust system to ensure staff were required to provide proof of the training they had completed or to record the completion date in order to enable the provider to identify when it needed to be refreshed. There was a lack of an effective system to identify how often staff had received supervision or spot checks of their work and when their next supervision was due. There was a lack of a robust system to enable the provider to identify if people's care was being reviewed three monthly as they required. The lack of effective systems had placed people at risk of receiving unsafe or poor quality care.

Staff told us the only aspect of the service they audited was people's medicine administration records (MAR), when staff returned them to the office monthly. Staff did not always routinely return people's MAR for topical medicines (creams), so they were not consistently reviewed. There was no written record of the checks completed on MARs or to demonstrate the actions office staff took if they identified any errors. We found 79 gaps in two people's MARs reviewed for January 2016 and there was no written evidence to demonstrate the actions taken to identify if the person had missed their medicines or if the staff member had forgotten to sign the MAR, or to reduce the risk of repetition. One person's MAR had not been signed for any of their medicines for one day. There was no evidence to demonstrate this had been investigated and appropriate action for this person. Processes to evaluate the safety and effectiveness of MARs for people and to ensure relevant actions were taken were inadequate.

There was no effective process to ensure care staff checked themselves that they had completed people's MAR at each visit. There was a lack of written evidence to demonstrate staff had reported to the office when they identified at people's care call that the MAR was incomplete. The lack of a process to require care staff to 'Self-check' that they had completed people's MAR had resulted in errors not being identified at the time they occurred to enable action to be taken to ensure people's safety.

No other aspects of the service had been audited, for example, people's care plans, to enable the provider to assess and monitor the quality of the service provided or staff recruitment files to ensure they all contained the same information. The provider did not use any data generated from incidents, late calls, missed calls, complaints, safeguarding's, compliments, infection control, staff supervisions, the MAR audits, staff training or staff vacancies to enable them to assess and monitor the quality of the service and to identify any trends or areas that could be improved for people.

In addition to the lack of robust records relating to the management of the regulated activity, people's care

records were not always complete. The provider told us there was not enough time for care staff to complete the records they needed to in relation to people's care. Records were not always dated to demonstrate when they had been written, for example, people's care plans and MARs were not always dated with the year. The provider told us about an incident that had recently occurred. The member of staff had correctly reported the incident and the correct action had been taken to safeguard the person from the risk of harm. However, when we asked to see the incident record the provider told us one had not been completed. An incident record had not been documented as required or reviewed by the provider to document the incident, the actions they took and to identify if any other action was needed. People were placed at potential risk as records relating to the provision of their care were not always complete.

People and their relatives provided mixed feedback regarding whether their views on the service had been sought. There was some evidence that people's views had been sought about the service they received, people could remember receiving feedback sheets which they or a relative had completed. The provider told us an external agency had been used to seek people's views and they had received 25 feedback forms to date. They said they had reviewed the results but had not used them to draw up an action plan to address any areas for improvement. Although most people's feedback was positive, some people had given aspects of the service a lower score. Their feedback highlighted issues in relation to recruitment, communication, staff knowledge of people and running of the company. Although staff told us these issues had been addressed with people there was a lack of written evidence to confirm this. There was a lack of evidence to demonstrate people's feedback had been used to improve the service.

The provider told us they held regular staff meetings to obtain feedback from staff. However, no records were kept of these meetings, nor were there any action points. Therefore it was not possible to assess their effectiveness as a forum for staff to raise and address issues for people.

The failure to operate effective systems in order to regularly assess and improve the quality of the care provided, mitigate risks to people, to securely maintain accurate records or to use information from the monitoring of the service to improve it were breaches of Regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

People's overall feedback was that the management of the service was inadequate. One person's feedback was that the service had "Lost their way". Everything was good for the first four months, then things went downhill and were a "Bit of a muddle." Another person told us it "Sometimes doesn't feel well-led or well organised. Managers are getting stuck in with providing care rather than managing. It would be an excellent company if managed a bit better." One person commented "Feels that things could be a run a bit more efficiently at the office."

Staff feedback on the management of the service was positive. One staff member told us the provider was "Brilliant" and another that "Management is approachable, very welcoming, feel able to raise concerns." However, the provider themselves told us one of the areas they had identified was the need to improve the level of communication between the office and care staff. Although the provider was aware of this need, they had no plans in place to address this for people.

Staff had not received an adequate level of training to carry out their role. The staff member witnessed not always upholding people's dignity and privacy to the required standard was not aware that they were not following good practice. The system of spot checks had not identified this staff member's poor practice. The provider told us that senior care staff did not receive supervision; therefore they were not provided with clear guidance about their roles and responsibilities. Although office staff had been told to audit people's MARs there was a lack of guidance for them about how to do this, which had led to the process being

inadequate and placed people at risk of not receiving their medicines safely. The provider had not ensured that where staff did not follow their requirements, for example, in relation to logging in and out of people's care calls they took appropriate action to ensure they did so. Action had not been taken when staff practice did not meet the provider's standards of care for people. Staff had received an inadequate level of training, support and guidance from management to ensure people received safe, high quality care.

The provider was also the registered manager and worked within the service on a daily basis. They told us they were responsible for completing new assessments and the supervision of all staff. There were three senior field care staff who were responsible for completing spot checks on staff, reviews of people's care and updating risk assessments. There were two office based co-ordinators who were responsible for the rostering of staff and a member of staff who was in charge of finance and IT. Office staff were also involved in providing people's care. Records demonstrated one of the co-ordinators had been scheduled to complete 21 hours of care in one week in addition to their office duties. The issues identified during the course of the inspection and people's feedback on the management of the service demonstrated that there was a lack of robust management and leadership. The provider was heavily involved in the delivery of the service rather than having the time to oversee and manage the service. The current management structure was insufficient to ensure the service was well managed and well-led for people.

People's feedback was that the working culture was good. One person told us "Culture seems generally good – carers are flexible in covering sickness, etc, and are loyal to the company." Another commented that "All staff seem quite happy in their jobs." Staff told us that they were happy working for the provider.

The staff handbook stated the provider's values were 'To ensure all of our service users are safe and their needs are met in a responsive manner that is individual to them, compassion and caring, team work, good communication, commitment to quality, mutual respect'. The provider told us staff learnt about their values during their four hour corporate induction, which records confirmed. Staff confirmed they had been made aware of the provider's values during their induction. The provider had not consistently upheld their own values in relation to ensuring people's safety or the quality of service.

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 Regulation 12 (1) (2)(c)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure staff providing people's care had the qualifications and competence to do so. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We issued the provider with a warning notice requiring them to ensure they met the requriements of this regulation by 30 June 2016

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) (2) (a) (b)(c) (d)(e) (f) of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014. The provider had failed to operate effective systems in order to regularly assess and improve the quality of the care provided, mitigate risks to people, to securely maintain accurate records or to use information from the monitoring of the service to improve it.

The enforcement action we took:

We issued the provider with a warning notice requiring them to ensure that they met the requirements of this regulation by 30 June 2016