Allied Healthcare Group Limited

Allied Healthcare - Oxford

Inspection Report

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Summary of findings

Overall summary

Allied Healthcare – Oxford is a service that provides nursing and personal care to people living in their own homes. At the time of our inspection the agency was providing services to 54 people.

At our last inspection in January 2014 we required the provider to make improvements to the way they safeguarded people from abuse, assessed and monitored the quality of service, and maintained their records. We found some, but not all, of these improvements had been completed.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

People we spoke with told us they felt safe being cared for by the service. Most people told us they felt confident to raise any concerns with members of staff, while other people said they would be happy to do this through family members.

We found, in most cases, people were protected from avoidable harm, abuse and breaches of their human rights. Staff were clear about how to identify prevent and report abuse and systems were in place to respond effectively to incidents of abuse.

However, we identified that a staff member had not followed a plan that had been put in place to protect the person they were caring for from financial abuse. We also found that arrangements to record purchases made by care staff on behalf of people who lacked mental capacity could not be audited. Consequently, people were not adequately protected from the risk of financial abuse.

Most other risks were identified, assessed and managed in a way that protected people effectively. We looked at the care plans for seven people and saw they each contained risk assessments which were reviewed regularly. However, an action to monitor and record the condition of people's skin was not being followed. The provider was, therefore, unable to demonstrate that people were protected effectively from the risk of developing pressure injuries.

The service followed safe recruitment practices. This meant only staff who were suitable to work with vulnerable people were employed by the service. Training records showed staff received appropriate training, although a member of the local authority commissioning team expressed concern about the number of subjects being taught during induction in a short space of time.

Two types of care plan were being used by the service; one for people receiving nursing care from live-in care workers and another for people receiving personal care on a domiciliary basis by staff who visited people in their own homes. We found the nursing care plans were comprehensive. However, personal care plans did not always describe how care and support should be delivered.

People told us they were involved in the assessment of their needs and the development of their care plan. We spoke with 14 people about the care and support they received. Most people told us they were satisfied with the service. However, we found five or the seven care plans we viewed were not up to date and did not reflect people's current needs.

We visited three people in their homes and observed interactions between them and staff. We saw people were relaxed and comfortable with staff and staff communicated with them in a friendly, yet dignified way. Staff clearly knew people well and understood their individual needs. We also heard office staff talking about people fondly and knowledgably. They were able to tell us about people's life histories, their interests and their preferences.

However, the comments and attitude demonstrated by one care worker did not show kindness or compassion for the person they supported and did not comply with the provider's policy of promoting choice and control.

We saw people's mental capacity was assessed and documented in care plans. However, two members of staff demonstrated a lack of understanding of the Mental Capacity Act 2005 and how to make decisions in people's best interests. This meant people's interests were not always protected and decisions may not have been made in accordance with the legislation.

Summary of findings

Live-in care workers told us they felt isolated and unsupported as they spent most of their time providing care on a one-to-one basis with little contact or support from colleagues. Although the service had recognised this, a policy they had agreed to develop to support live-in care workers, following our inspection in August 2013, had not been completed. This meant live-in care workers were not supported to deliver care to a safe and appropriate standard.

The concerns we identified meant there had been a breach of the relevant regulation (Regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the service was safe, but improvements were needed.

We identified that a staff member had not followed a plan that had been put in place to protect the person they were caring for from financial abuse. We also found that arrangements for managing people's money were not adequate in all cases.

Most other risks were identified, assessed and managed in a way that protected people effectively. However, an action for staff to monitor and record the condition of people's skin on a daily basis was not being followed. The provider was, therefore, unable to demonstrate that people were protected effectively from the risk of developing pressure injuries.

People we spoke with told us they felt safe being cared for by staff from the service and felt confident to raise concerns with staff. Staff had received training in safeguarding and were clear about how to identify, prevent and report abuse.

The service followed safe recruitment practices. This meant only staff who were suitable to work with vulnerable people were employed by the service.

People with nursing needs were assessed by a registered nurse, who developed their care plan and oversaw their care and treatment. Additional training was provided to care staff to give them the skills and knowledge needed to deliver particular care safely, such as that related to diabetes, catheters or gastric feeding tubes.

Are services effective?

We found the service was effective, but improvements were needed.

Two types of care plan were being used by the service; one for people receiving nursing care from live-in care workers and another for people receiving personal care on a domiciliary basis. We found the nursing care plans were comprehensive. However, personal care plans did not always describe how care and support should be delivered.

We also found five of the seven care plans we viewed were not up to date and did not reflect people's current needs. This meant people may have been at risk of receiving inappropriate care and treatment as an accurate record of their needs had not been maintained.

Summary of findings

Records showed staff training was up to date, although a member of the local authority commissioning team expressed concerns about the effectiveness of staff induction training.

A computerised 'early warning system' was used to alert office staff to changes in people's health, so appropriate referrals could be made. This alerted office staff to the need for referral or intervention by health care professionals such as community nurses. Records showed the system was being used appropriately.

We spoke with 14 people about the care and support they received. Most people told us they were satisfied with the service.

Are services caring?

We found the service was caring, but improvements were needed.

In the case of one member of staff who we spoke with in the office, we found the language used to describe the support they provided was not appropriate and demonstrated a lack of understanding of their role. Their approach did not comply with the provider's policy on privacy, dignity and respect.

People did not always receive care from a consistent group of staff who knew and understood their needs, although they did receive a rota each week informing them which staff would be visiting each day.

Most people told us they felt they were treated with care and kindness, although two people said they were not always treated with dignity.

When we visited three people in their homes, we observed interactions between them and staff. Staff clearly knew people well and understood their individual needs. We also heard office staff talking about people respectfully.

Are services responsive to people's needs?

We found the service was responsive to people's needs, but improvements were needed.

We saw people's mental capacity was assessed and documented in their care plans. However, two members of staff demonstrated a lack of understanding of the Mental Capacity Act 2005 and how to make decisions in people's best interests.

People told us they were not always given a choice of male or female care staff or the time that care workers attended. This meant

they were not involved in making choices about this aspect of their care. However, all said they were happy with arrangements that were in place. Some people had requested a change of care worker and we saw the service had responded positively to these requests.

The service had a complaints policy and information was given to people, or their families, when they first started receiving the service. We saw examples of individual complaints that had been made and responded to appropriately, showing the provider responded appropriately to people's concerns.

People were encouraged to make their views known about the care and support they received and opportunities were provided for this. The provider conducted an annual survey of people using the service and had arrangements in place to address any concerns identified.

Are services well-led?

We found not all aspects of the service were well-led.

The service had a registered manager in place who had other responsibilities within the company. This mean they were not able to devote all their time to this service. The service had also appointed a local manager to assist in running the service.

We found the service had an open culture with a number of communication channels used to keep staff informed of current issues and to send and reinforce topical messages. However, three members of staff told us they felt communication with the service could be improved.

Live-in care workers said they felt isolated and unsupported as they spent most of their time providing care on a one-to-one basis with little contact or support from colleagues. The service had recognised this, but had not implemented a policy to address it. This meant live-in care workers were not supported to deliver care to a safe and appropriate standard.

The service used a range of systems and audits to monitor its quality of service. However, these were not always effective as they had not identified shortfalls found during this inspection.

During our inspection, when we raised concerns about two issues, the registered manager responded swiftly by commencing investigations. Staff were interviewed and measures immediately put in place to safeguard the people concerned.

Most people using the service told us that communication with the service was effective and said things had improved in recent months.

Summary of findings

Staff told us they had access to a whistle blowing line and said they would be supported if they had cause to raise concerns about unsafe practices.

There was an appropriate system in place to ensure there were sufficient numbers of staff, with the right skills and experience to meet the needs of people at all times.

Summary of findings

What people who use the service and those that matter to them say

Most people told us they felt

Some people said they did not always have the same care staff. One person told us "It would be nice to have the same group of carers. Someone turned up this morning and we haven't seen her before.It takes time for them to get to know what needs doing." Another person said, "They keep changing the carers." However, people told us they usually received a rota telling them which member of staff would be visiting each day.

When we asked people about the choices they were able to make, we received mixed responses. One person said, "I was given a choice of a male or female carer and I was also asked when I wanted my care." Another person told us, "Just recently – say six months, they have been coming at the time that we want." Other people told us they could not recall having been given any choice, but were happy with the arrangements. One person said, "I was not given a choice of a male or female carer, nor the time of my care, but I am happy with that." Another person told us they were "not given the choice, but have always had what I wanted".

Most people told us staff arrived on time, although three people said there had been times when staff had not arrived or had arrived late. One person told us this had happened "many times, too many to recall, especially at weekends". Another person said it had happened "once or twice".

People told us that communication with the service was effective and said things had improved in recent months. One person said, "Yes, you phone the agency and if you have a problem they sort it out for you. They do answer the phone." Another person told us "When we call them it goes through to a central location – I have phoned them on many occasions, they seem very amiable, friendly. They are pretty good; they say "yes" to everything and take on board your grievances." However, one person told us the service "does not ring you back" and another person said of the local office "The left hand doesn't seem to know what the right hand is doing".

People we spoke with told us they felt safe being cared for by the service and trusted staff to do shopping for them. One person said, "I give them the money and they come back with the receipts and change."

Most people told us they were satisfied with the service. Comments included: "I'm very happy with the care"; "The people that come are very good"; and "No complaints about the care." They also said they could access healthcare support when required.

People told us they were involved in the assessment of their needs and the development of their care plan. One person said, "The agency sat with me and went through everything about me and what I wanted." Another person, speaking about a review of their care plan, said of the staff member, "They went through different points and checked I was happy with it."

Allied Healthcare - Oxford

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

The inspection team consisted of a lead inspector and an Expert by Experience who had experience of people receiving care in their own homes.

We visited the service on 23 and 24 April 2014. We spent time in the service's office looking at records, including seven people's care records, training records and records relating to the management of the service. We spoke with 11 members of staff and the registered manager. We also visited three people in their homes where we talked with them and observed the way staff interacted with them. Following the inspection, we spoke with a further 11 people by telephone and also spoke with staff from the local safeguarding authority.

Before the inspection we reviewed all the information we held about the service and spoke with a member of the local authority commissioning team.

At our last inspection, in January 2014, we identified the service was not meeting essential standards in respect of safeguarding people and assessing and monitoring the quality of service. We issued warning notices for these breaches and required the service to make improvements by 18 March 2014. We also identified the service was not meeting the regulations in relation to record keeping. The provider sent us an action plan detailing how they would meet this standard by 31 March 2014.

Are services safe?

Our findings

We spoke with six members of staff who were clear about how to identify, prevent and report abuse using the provider's internal systems. They told us they had recently received written guidance about safeguarding adults. However, we found three staff members were not aware of how to report concerns externally, to the local safeguarding authority, and one staff member was not familiar with safeguarding terminology. This meant concerns might not be reported appropriately.

We looked at the care records for one person who we saw had a 'personalised individual plan for financial arrangements' and a financial risk assessment in place. The registered manager told us this had been written following a safeguarding strategy meeting held in December 2013. This person had been identified as at risk of financial abuse and did not have the mental capacity to manage their own money. The plan stated that arrangements had been made for the live-in care worker to have access to small amounts of money only, so they could support the person to make day to day purchases. When we visited this person, we found the plan had not been followed; the live-in care worker had supported the person to withdraw a large sum of money the previous week, which was not being stored securely. This put the person at high risk of financial abuse. We brought this to the attention of the registered manager and alerted the local safeguarding authority to this concern.

We looked at the arrangements for recording money spent by staff on behalf of the people they were supporting. We saw a transaction log was kept. This showed how much money had been given to the staff member, how much had been spent and how much change had been returned to the person. Receipts were kept with the log to confirm the purchases. Where people were unable to check and sign the transaction logs, due to a lack of mental capacity or physical ability, we found the logs had only been signed by one staff member. In the case of one person, whose live-in care worker looked after their money for them, we saw there was no record of how much money was added to the person's money box each week. This meant it was not possible to audit the transaction log to check that all money was properly accounted for. These arrangements did not protect the person adequately from the risk of financial abuse.

However, where the person was able to check and countersign the log to show it was accurate, we saw this had been done. People told us they trusted their care workers with their money. One person said, "I give them the money and they come back with the receipts and change. I check the change and receipt." Another person told us "I check the change is correct. The carer writes amount spent and the change she has given me and I sign it, as she does."

Other risks were identified, assessed and managed in a way that protected people effectively. We looked at care plans for seven people and saw they each contained risk assessments. These included the risk of people falling, developing pressure injuries, acquiring an infection or presenting behaviour which may challenge others. They specified actions required to protect people from harm. Records of daily care showed most of these actions were implemented by staff. For example, we saw people who needed to be turned regularly to prevent pressure injuries had been turned as required. We saw assessments were reviewed every six months or when people's circumstances changed, which meant they were up to date and relevant.

However, we found one action, detailed in the risk assessments of six people, was not being followed by staff. The action required staff to monitor and record the condition of people's skin on a daily basis so early signs of skin breakdown could be identified. We looked at the records for these six people and saw their skin condition was not being recorded. The provider was, therefore, unable to demonstrate that people were protected effectively from the risk of developing pressure injuries.

The operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of people were not effective. This meant there had been a breach of the relevant regulation (Regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

The service provided care to people who required nursing care and personal care. We saw that people with nursing needs were assessed by a registered nurse, who developed their care plan and oversaw their care and treatment. Where required, the registered nurse or a community nurse provided additional training to care staff to provide them

Are services safe?

with the skills and knowledge needed to deliver particular care, such as that related to diabetes, catheters or gastric feeding tubes. Care and treatment were, therefore, provided safely by suitably trained staff.

The service followed safe recruitment practices. We discussed the procedures used to recruit new staff with the registered manager and the member of staff responsible for employing new care workers. They told us they had access to support and advice from the provider's head office to ensure potential recruits were vetted correctly. We looked at the staff files for three people who had been recruited recently. The files included application forms, records of interview and appropriate references. We saw the necessary checks had been made with the Disclosure and Barring Service to see if applicants had criminal records or were barred from working with vulnerable people. The process used meant only staff who were suitable to work with vulnerable people were employed by the service.

We looked at the service's policies on safeguarding and whistle blowing. We saw these were up to date and appropriate for this type of service. Staff records showed all staff had received training in safeguarding and most staff had also attended a refresher training session since our last inspection. Staff supervision records showed their awareness of safeguarding issues was checked at the time of their supervision, through a knowledge check.

The registered manager and two senior members of staff demonstrated a clear understanding of how safeguarding incidents were recorded, investigated and analysed. We looked at the system used for this purpose and saw examples of recent safeguarding alerts that had been dealt with in accordance with the joint working arrangements between the provider and the local safeguarding authority.

People we spoke with told us they felt safe being cared for by staff from the service. Most people said they felt confident to raise any concerns with members of staff, while other people said they would be happy to do this through family members.

Allocation of staff to undertake visits to people receiving domiciliary care or care from live-in care workers was arranged by coordinators based in the office. When we spoke with them, we found they had a good understanding of people's individual needs and the capabilities of each staff member. They explained how they ensured that each visit was undertaken by a staff member with the necessary skills. Where they were unable to find a staff member to cover a visit, for example due to sickness, they would often attend themselves; they maintained their training to a level that allowed them to do this effectively. Records confirmed they had done this, for example when a person had returned home at short notice. This provided additional cover to cope with unexpected or emergency situations.

Are services effective?

(for example, treatment is effective)

Our findings

We looked at care plans for seven people using the service. We found that since our last inspection these, and all other care plans, had been reviewed. However, the reviews had not been effective as some care plans were not comprehensive and did not reflect people's current needs.

Two types of care plan were being used by the service; one for people receiving nursing care from live-in care workers and another for people receiving personal care on a domiciliary basis. We found the nursing care plans were comprehensive and described fully the care and support each person required and how this should be delivered. However, the personal care plans were not comprehensive and did not always describe how care and support should be delivered. For example, one person's care plan stated "At bedtime I require assistance to use the toilet, get washed and then dressed for bed." It did not describe what assistance was required or the way in which it should be provided.

Four people's continence care plans were not up to date and did not describe the care being provided by care staff accurately. For example, one person was described as continent in their care plan, but care staff told us the person needed to wear continence pads. Care staff also told us this person needed a particular cream rubbing into their legs, and we saw the community nurse had trained staff to do this. However, this was not recorded in the person's care plan.

The care plan for another person did not provide sufficient information about how they wished to be supported to wash and dress. The person's live-in care worker told us other aspects of the person's care plan were also out of date. For another person, we found the version of the care plan kept in their home was at odds with the newer version that was kept in the service's office.

Therefore, whilst the regular care workers were aware of the people's individual needs, an unfamiliar member of staff would not have been able to provide appropriate care and support from the information contained within the care plans. There was a risk that people would not receive appropriate safe or effective care in a consistent way. The systems used to ensure care plans were up to date were not effective. This meant there had been a breach of the relevant regulation (Regulation 10(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Staff received appropriate supervision and appraisal. We looked at staff records for three members of care staff. We saw each had received 'spot checks' and a session of supervision with a supervisor every three months. In addition, each had received an appraisal within the past year. Supervision and appraisal sessions were used to identify learning and development needs.

We spoke with the staff member responsible for training and viewed the provider's training policy. We saw new staff completed a four day training programme which covered key subjects, such as management of medicines, safeguarding, moving and handling, infection control and dementia. Staff told us the training had given them sufficient knowledge to perform their role, although one staff member said, "There was so much, so quickly, it was difficult to absorb."

We spoke with a member of the local authority commissioning team about training at the service. They expressed concerns about the effectiveness of covering 44 topics, in addition to medication and safeguarding, in such a short period. They told us they had asked the service to extend the training period in order to equip staff more effectively for their role. The staff member responsible for training told us an additional day's training had been agreed with the provider for future courses. This would ensure that future training was effective and new staff had sufficient time to absorb the content of all the topics covered.

We looked at records of training for established staff. These showed they had received training in accordance with the provider's policy. A computerised systems alerted senior staff members to when staff training needs to be refreshed and the service had a policy which prevented staff from working if their training became out of date. This ensured staff knowledge remained up to date in all key areas.

We spoke with 14 people about the care and support they received. Most people told us they were satisfied with the service. Comments included: "I'm very happy with the care"; "The people that come are very good"; and "No complaints about the care".

Are services effective?

(for example, treatment is effective)

People told us they could access healthcare support when required. Care records showed people had been supported on visits to their GP and had been referred to specialists when required, including speech and language therapists. A computerised 'early warning system' was used to alert office staff to changes in people's health. This prompted office staff to request referrals to, or intervention by, health care professionals such as community nurses. Records showed the system was being used appropriately.

People told us they were involved in the assessment of their needs and the development of their care plan. One person said, "The agency sat with me and went through everything about me and what I wanted." Each care plan viewed contained an assessment of the person's individual needs and was signed by the person or a close family member to confirm they understood and agreed to the care and support offered. Records showed that one of the coordinators regularly visited people to discuss their care to ensure they were happy with the way it was being delivered. Another person told us "They went through different points and checked I was happy with it."

Are services caring?

Our findings

Most people told us they felt

When we spoke with a member of staff who provided live-in care to a person who had the mental capacity to make decisions, we found the language used to describe the support they provided was not appropriate. It demonstrated a lack of understanding by the staff member of their role and the person's right to make choices about what they ate and drank. Comments had been recorded by the care worker in the person's daily records showing they imposed an inappropriate degree of control over the person's choices. We brought these concerns to the attention of the registered manager who agreed the comments that had been recorded were not appropriate.

We viewed the provider's policy relating to people's privacy, dignity and respect. We found this was up to date and appropriate for this type of service. It included a list of "dignity factors" that it said contributed towards a person's sense of self-respect. The list included offering the person "Choice and Control". The language and comments made by the above care worker were not in line with the provider's policy of promoting choice and control.

Two people told us they usually had the same care worker and two people said there was "a rota of two or three" staff who visited. However, three people said they did not always have the same care staff. One person told us "It would be nice to have the same group of carers. Someone turned up this morning and we haven't seen her before.It takes time for them to get to know what needs doing." Another person said, "They keep changing the carers." People did not always receive from care from a consistent group of staff who knew and understood their needs.

Most people told us they usually received a rota from the service telling them which care worker would be attending each visit. One person said, "The rota usually comes on a Saturday or a Monday. I get a letter every week which gives me the time when the carer will come and how long she will be here."

We visited three people in their homes and observed interactions between them and staff. We saw people were relaxed and comfortable with staff and staff communicated with them in a friendly, yet dignified way. Staff clearly knew people well and understood their individual needs. We also heard office staff talking about people respectfully. They were able to tell us about people's life histories, their interests and their preferences.

The service shared the care of some people with other care agencies or health care providers. For example, when a live-in care worker took a break, staff from another care agency provided cover. We saw systems were in place to share information with and between these agencies. People told us there were "no problems" with their shared care and that the arrangements worked satisfactorily.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Most people also told us staff arrived on time, although three people said there had been times when staff had not arrived or had arrived late. One person told us this had happened "many times, too many to recall, especially at weekends." Another person said it had happened "once or twice." A third person told us they were upset when their care worker arrived late, so was not available to help them when they returned from a day centre. However, one person said "They may have been a bit late, but they always ring from the office to let me know."

We looked at seven care plans and saw people's mental capacity was assessed and documented. However, two members of staff demonstrated a lack of understanding of the Mental Capacity Act 2005 (MCA) and how to make decisions in people's best interests when they lacked the capacity to make specific decisions themselves. One staff member supported a person to withdraw a large sum of money, which put the person at risk of financial abuse. Another staff member told us they did not have an understanding of MCA and could not remember whether it had been covered during their induction training. There was no system in place to make sure training was effective in providing staff with an understanding of their role and the legislation designed to protect people's rights. This meant there had been a breach of the relevant regulation (Regulation 10(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

When we asked people about the choices they were able to make, we received mixed responses. One person said, "I was given a choice of a male or female carer and I was also asked when I wanted my care." Another person told us, "Just recently – say six months, they have been coming at the time that we want." Other people told us they could not recall having been given any choice, but were happy with the arrangements. One person said, "I was not given a choice of a male or female carer, nor the time of my care, but I am happy with that." Another person told us they were "not given the choice, but have always had what I wanted."

Some people told us they had requested a change of care worker, for a variety of reasons. We found the service had responded to these requests and made adjustments to suit people's preferences.

People were encouraged to make decisions about their care and treatment. For example, staff explained how they supported people to make decisions about what they wanted to wear each day and what they wanted to eat at each meal. One person with a degenerative condition told us they had chosen not to take any medication because they found the side effects of the medication worse than the condition itself. Their decision was respected by staff, which allowed the person to retain control over how they chose to live their life

The service had a complaints policy and information was given to people, or their families, when they first started receiving the service. On the computer system used to record and manage complaints, we saw examples of individual complaints that had been made and responded to appropriately. One case had required the service to conduct an investigation and we saw statements had been taken and comprehensive investigation notes recorded. The person concerned had been informed of the findings of the investigation in a timely manner and was satisfied with the outcome.

People were encouraged to make their views known about their care and support. Senior staff members visited people receiving live-in care on a weekly basis, and those receiving domiciliary care on a monthly basis. These visits provided an opportunity for people to discuss their care and support and make their views known. We saw copies of "customer quality review" forms on people's care plans, confirming this had occurred. Additionally, when staff received supervision and appraisal, people were asked to comment on the performance of the staff member concerned.

The provider also conducted an annual survey of people using the service, together with random sampling of people on a frequency based on the level of satisfaction expressed in the last survey. We saw goals were then set to address concerns identified in the survey, and the analysis of audits. Target dates were given for achieving the goals and the service had a system in place to monitor their progress.

Are services well-led?

Our findings

The service had a registered manager in post. The registered manager was also registered to manage a similar service in another county and held another senior role in the organisation. This meant they were not able to devote all of their time to this service, but told us they spent "two to three days a week" there. The service had also appointed a local manager to assist in running the service.

Staff told us they felt communication with the service could be improved. For example, one member of staff told us they had asked for support to complete a vocational qualification last year, but had not received a response to their request.

Live-in care workers said they felt isolated and unsupported as they spent most of their time providing care on a one-to-one basis with little contact or support from colleagues. The service had recognised this and, following our inspection in August 2013, the service produced an action plan telling us they would develop a policy to show how live-in care workers would be supported appropriately. At this inspection, in April 2014, the registered manager told us the policy was "still being developed". As an interim measure, a live-in care workers' meeting had been organised for the second day of our inspection. Staff told us this had been useful and they had appreciated the opportunity to share experiences and concerns with colleagues. Following the inspection, the provider told us there was a policy in place since December 2013 (before the inspection). However, the manager told us this policy was in development. Because they were unaware of it, this meant they could not implement it.

The lack of effective support for live-in care workers meant they may not have been able to provide appropriate and effective care to people. The failure to complete the previously agreed action plan, and implement a policy to support live-in care workers, meant there had been a breach of the relevant regulation (Regulation10(2)(b)(v) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

We found not all quality assurance systems were working effectively. For example, although an audit had shown that all care plans had been reviewed, it had not identified that some did not reflect people's current needs. Another system, used to audit "visit report books" had identified poor record keeping in one person's report book, but this was not addressed until three weeks later when we also identified the issue during our inspection.

The fact that audits undertaken by the service had not identified shortfalls identified by this inspection, and prompt action was not always taken to address concerns, meant there had been a breach of the relevant regulation (Regulation 10(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end of this report.

Most people told us that communication with the service was effective and said things had improved in recent months. During office hours they said they could call the local office, and out of hours they were able to contact a central location. One person said, "Yes, you phone the agency and if you have a problem they sort it out for you. They do answer the phone." Another person told us "When we call them it goes through to a central location – I have phoned them on many occasions, they seem very amiable, friendly. They are pretty good; they say "yes" to everything and take on board your grievances." However, one person told us the service "does not ring you back" and that care workers did not always attend when required. Another person said of the local office "The left hand doesn't seem to know what the right hand is doing."

We looked at the system used to manage accidents and incidents. We found this was being used effectively to capture details of concerning incidents or accidents which had occurred. The system allowed senior staff to identify the root cause of incidents and analyse trends. For example, we saw an issue relating to possible financial abuse had been recognised, reported to the local safeguarding authority and had been discussed with staff during a team meeting.

We also saw this being used during our inspection when we raised concerns about two issues. The registered manager responded swiftly by commencing investigations. Staff were interviewed and measures immediately put in place to safeguard the people concerned. One case, we were later told, had led to a staff member receiving additional training.

There were appropriate arrangements in place to ensure there were sufficient numbers of staff, with the right skills

Are services well-led?

and experience to meet the needs of people at all times. Staffing levels were reviewed regularly and additional recruitment undertaken when needed. The provider employed sufficient training staff to enable them to provide all training 'in house', with the flexibility to run induction training for new staff as and when required.

We found the service had a number of communication channels used to keep staff informed of current issues and to send and reinforce topical messages. These included the use of open plan offices by managers and a system called "myconnected" which allowed staff to express their views via discussion groups. Other communications were circulated via a "post bag" system that categorised information that should be shared with staff according to how urgent it was. This ensured staff were kept informed and aware of key messages.

We saw regular team meetings were held with staff and minutes showed these provided an opportunity for staff to express their views about the service and how it could be improved. The meetings were also used to refresh training on topical subjects.

Staff told us they had access to a whistle blowing line, the number of which was printed on their payslips. They said they would be supported if they had cause to raise concerns about unsafe practices. One staff member told us they had done this, in relation to concerns about the recording of medication administered by a colleague, and was satisfied with the service's response.

The relevant regulation, (Regulation 10(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010), which we identified the service had breached in August 2013, was continuing to be breached at the time of this inspection in April 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	Regulation 10(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The registered person had not protected service users against the risks of unsafe or inappropriate care and treatment by means of the effective operation of systems designed to enable them to regularly assess and monitor the quality of the services provided and by the effective operation of systems designed to enable them to identify, assess and manage the risks relating to the health, welfare and safety of service users.