Guinness Care and Support Limited

Guinness Care At Home Hampshire

Inspection report

33 East Street
Havant
Hampshire
PO9 1AA

Tel: 02392714952
Website: www.guinnesspartnership.com

Date of inspection visit:
29 October 2018
06 November 2018

Date of publication:
24 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Guinness Care at Home Hampshire is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people living with dementia, people with a mental health condition, physical and learning disabilities, sensory impairments and younger adults.

At the time of the inspection, the service was providing care and support to 72 people. Each person received a variety of care hours, depending on their level of need. The Care Quality Commission (CQC) only inspect the services being received by people provided with 'personal care'; such as help with tasks related to personal hygiene and eating. Where this is provided, we also take into account any wider social care provided.

Inspection activity started on 29 October 2018 and ended on 6 November 2018. This inspection was announced. We gave the provider 48 hours' notice of our inspection as we needed to be sure key members of staff would be available.

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

This was the first inspection of the service since it was registered with the Care Quality Commission.

Quality assurance processes were in place; however, they had not identified the areas of concerns we found during this inspection relating to the safe management of medicines, risks to people, staff knowledge of people's care plans, reviews of care documentation, timeliness of care calls and the impact of office staff shortage.

Medicines were not always managed safely. Administration of people's medicines was documented in an unclear and inconsistent manner. The registered manager was not clear of the correct recording process that staff should be following when using medicines were not administered.

Where individual risks to people were identified, these were not thoroughly documented and there was a lack of information for staff to minimise the risk of harm.

There were not enough staff deployed to ensure that people received care and support in a safe and timely manner.

Staff were not always familiar with the information in people's care plans, to ensure they were delivering care and support in line with people's preferences and needs.

There was a shortage of office staff which impacted upon their responsibilities to complete management tasks and provide consistency of communication with people.

People did not always have choice and control over how their care was delivered. People were not always informed if there was going to be changes to their care calls.

There were appropriate recruitment procedures place to ensure that new staff members employed were suitable to support people in the community.

Staff had received training in safeguarding and undertook their responsibilities to identify and report signs of potential abuse.

There were robust processes in place to protect people from the risk of infection and staff wore personal protection equipment (PPE) appropriately.

New staff received a robust induction period before they worked independently with people, which included training in key areas and shadow shifts with a senior member of staff. Existing staff received regular refresher training and were encouraged to enrol onto additional training courses.

People were supported to access healthcare services when needed and staff acted appropriately where people's health needs changed.

Although people had the capacity to make decisions about their care and support, people's rights were protected in line with the Mental Capacity Act 2005 and staff sought people's consent appropriately.

Staff had developed positive relationships with people and their families and treated them in a kind, compassionate and respectful manner.

Staff took action to protect people's dignity and privacy at all times and encouraged people to be independent with all aspects of their daily routines where possible.

Information about people's end of life wishes was not recorded, however the registered manager and staff were aware of their responsibilities to ensure people's end of life choices were followed.

The service had a clear process in place to deal with complaints and we saw that concerns were dealt with in a timely and effective manner.

Staff received regular updates about changes in the service and felt valued in their role. Staff were recognised for doing a good job and were notified if they received positive feedback from the people they supported.

The provider supported the registered manager and was engaged in running the service. There was a positive and open culture and the vision and values of the service were actively promoted.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Records of medicines administration were completed in an unclear and inconsistent manner.

Information about individual risks to people was not fully documented for staff to ensure that the risk was minimised.

There were not enough staff to ensure people's needs were being met safely or in a timely manner.

Appropriate recruitment procedures were in place to ensure new staff were suitable to be employed.

People were protected from the risk of abuse by staff who had received training in safeguarding.

Procedures were in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff were skilled, knowledgeable and competent to carry out their roles.

New staff received a robust induction period before they worked independently with people and staff felt supported in their role.

Staff worked together co-operatively for the benefit of delivering effective care and support.

People were supported to access healthcare services when needed.

People's rights were protected in line with the Mental Capacity Act 2005 and staff sought people's consent appropriately.

Is the service caring?

Good

The service was caring.

Staff treated people in a kind, compassionate and respectful manner.

Staff had developed positive relationships with people and their families.

Staff ensured that people's dignity and privacy was respected at all times.

People were encouraged to be as independent as possible in their day to day routines.

Confidential information was stored appropriately and securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have choice and control over how their care was delivered. People were not informed if there was changes to their care calls.

People's care plans were personalised and contained clear information about how to meet each person's needs.

Information about people's end of life wishes was not recorded, however the registered manager and staff were aware of their responsibilities to ensure people's end of life choices were followed.

There was a complaints procedure in place to ensure that concerns were investigated and dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance process was in place; however, this had not identified all the areas of concerns we found during this inspection.

Staff felt valued in their role and were recognised for doing a good job.

The provider was engaged in running the service and there was a positive and open culture.

Guinness Care At Home Hampshire

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was announced; we gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

Inspection activity started on 29 October 2018 and ended 6 November 2018. It included telephone conversations with people using the service and their relatives and telephone conversations with staff. We visited the office location on 29 October 2018 and 6 November 2018.

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 any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with 13 people who used the service and 12 relatives by telephone. We spoke with the registered manager, a care co-ordinator and five care staff. We looked at care records for seven people. We also reviewed records about how the service was managed, including staff training and recruitment records, policies and procedures and quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. Most people using the service were able to manage their medicines independently, however some people required support from staff to administer their medicines or apply topical creams. Medicines administration records (MAR) were not always completed correctly, which meant that we could not be assured people were receiving their medicines safely. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. We found that MAR charts were completed in an unclear and inconsistent manner, which made them difficult to read and understand. For example, on one person's MAR chart, the name of a topical cream had been handwritten as being administered, however when we showed this to the registered manager, they were initially unable to read what the name of the cream was. Where a numerical code was used to give a reason why medicines had not been administered, this was inconsistent and additional information for the reason had not always been documented in line with the provider's procedure. We raised this with the registered manager, who was not fully aware of the provider's policy that staff should be following. They told us they would hold a meeting to confirm the expectation of staff when completing MAR charts correctly.

MAR charts were kept in people's homes and returned to the office on a monthly basis to be audited. The registered manager advised that the audit procedure had recently been reviewed to ensure that 100 percent of MAR charts were audited. They told us that since the change, there had been a decrease in the amount of medicine errors taking place, however audit processes had not identified the concerns raised during the inspection. For example, a numerical code used on one person's MAR chart showed that a topical cream was 'not available' for a period of 25 days out of 31 days and this had not been picked up within the audit for action to be taken. We spoke with a senior member of staff, who confirmed that this type of concern should have been identified and followed up during the audit procedure.

Where individual risks to people had been identified, information was not always available to staff in people's care documentation to ensure that the risk of harm was reduced. For example, one person was identified as being at high risk of choking. A risk assessment stated that care staff should "make sure [the person] is positioned correctly", however there was no guidance available for staff to know what this position should be, why the person was at risk of choking, or what to do if the person started to choke.

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

We discussed these concerns with the registered manager who told us they were currently reviewing people's care documentation to ensure information was available for staff to manage potential risks appropriately.

There were not enough staff deployed to meet people's needs in a safe or timely manner. Most people we spoke with told us that staff were often late to the care call. People's comments included: "They've been late, a couple of hours sometimes. They are often half an hour late, they can't help that, I appreciate that,

but it's nearly all the time", "Sometimes they don't turn up and sometimes they don't stay and do the job" and "It's just the frustration of [staff] not turning up when they should that spoils things. I think maybe they have more work than they have staff for." Staff told us they did not always have sufficient time to travel between care calls, which meant they were often late. One staff member said, "[Travel time] can be a bit demanding. They give you between five and ten minutes sometimes, which isn't a lot, especially during busy times." Another staff member said, "There's definitely not enough travel time, you are always chasing your tail" and a third said, "You always turn up over your travel time anyway."

We discussed this with the registered manager who explained that if staff were going to be 20 minutes earlier or later than the time of the expected care call, they were expected to ring the client themselves or ring the office to pass the message on. However, we found that this did not always happen. People's comments included, "They are sometimes late arriving and frustratingly they don't let me know, so I am left wondering what is happening" ; "They are not good at turning up and I've had missed calls. No one phones to tell you if they're not coming" and, "[On one occasion] the carer was an hour late, she was held up with the one before me. She said the office should have rang me, but they didn't call me." Although staff were aware of the procedure of notifying people if they were going to be late, this was not effective or consistent.

At the time of the inspection, there had been a number of changes to staffing, which resulted in a notable shortage of office staff. Due to the lack of senior office support, we found this had impacted upon their abilities to complete all required management duties. For example, there was a lack of consistency in scheduled reviews of people's care plans, risk assessments and staff supervisions. There was a lack of communication between office staff, care staff in the community and people who received a service. People commented that it was often difficult to get hold of a member of staff in the office. One person said, "They don't answer the phone and you give up in the end" and another person said, "The management side isn't managing very well. They need to sort out who is responsible for calling people when they're going to be late. No one answers the phone, no one takes any notice." We raised this with the registered manager who acknowledged the communication difficulty they were facing due to the shortage of office staff. They advised that plans were in place for office staff numbers to increase in upcoming months, which would lighten the current workload for existing staff.

Furthermore, we found that staff were often rushed and did not always have enough time to read through the information about people's care needs, in order to support people safely. People and their relatives expressed their concern that staff did not always read through the care plan. One person said, "They don't read the care plan so I end up having to explain everything" and another said, "I do feel in control of what they do for me, although they never read the care plan." A relative told us, "I get nervous if they're new because they don't read the care plan." Staff told us they were not always able to familiarise themselves with information in people's care plans, due to a lack of allocated time. One staff member commented, "Most of the clients that I go to are regular, but there are others that are not so regular. This can be quite stressful, especially if things change in the care plan. If you get there early enough you can read care plan, but otherwise you can't." Another staff member said, "When you go in, that's the only chance you get to see the care plan, which can be a bit tricky, it's not great if you are going to someone new" and a third said, "There have been a few times where I have not known people. We have information on our work phones about their illnesses and routines. It's personalised as possible I guess, but obviously it's not a big space, so it's not a start to finish list of what you're expected to do."

The registered manager explained that most people did not have an regular 'team' of care staff, which meant that people often received care from a number of new and different care staff. This posed a further risk of not delivering care and support in line with people's wishes. Where staff were new or they had not met someone before, they were not always given sufficient information about the person's care needs.

The failure to ensure that sufficient staff were deployed to meet people's needs, was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were robust staff recruitment procedures in place. Appropriate arrangements were followed to ensure that staff were suitable to be employed at the service. Staff recruitment records for six members of staff showed that the provider had operated thorough recruitment checks in line with their policies and procedures to keep people safe. These included the completion of Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. There was a formal approach to interviews with records kept demonstrating why applicants had been employed and staff files included application forms, references and health declarations.

People were protected from the risk of abuse by staff who demonstrated a comprehensive knowledge and understanding of how to identify signs of abuse. Staff were clear about whom they would report their concerns to and had confidence that concerns would be actioned promptly by the registered manager or senior office team. Staff participated in annual safeguarding training and all staff were up-to-date with this element of their training. Staff were aware of agencies they could go to outside the organisation if they felt their concerns were not being handled appropriately by the registered manager. The provider had a whistleblowing policy and staff were aware of it and how to access the policy if they needed to.

There were appropriate systems in place to protect people by the prevention and control of infection. The registered manager was aware of the action they should take should people have an infectious condition within the service. Staff had attended infection control training and confirmed they had access to personal protective equipment (PPE), including disposable gloves and aprons. People and their relatives told us staff always wore appropriate PPE when they were being supported. They commented, "Yes, they always do" and, "Yes, every time."

There was a process in place to review and investigate accidents and incidents. Where incidents had occurred, the registered manager completed incident reports and investigation forms in detail, which were sent to the provider to monitor. Where relevant, appropriate actions were taken to ensure lessons could be learnt from what had happened.

Good

Is the service effective?

Our findings

People received effective care from experienced, knowledgeable and competent staff. People's comments included, "'Yes [they are trained well], I'd say they are faultless", "I've never had any problems with them and the way they treat me. They always ask me what I want them to do each time they come and they are very helpful" and "They know me and what has to be done so it's all very routine." A relative commented, "We've found them very good. The ones that come to us are very well trained and [my relative] is definitely in control of her care. Even though they know what needs doing, they always ask her what she wants and follow her lead."

New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training as required by the provider. A staff member said, "When I first started, the training was really good. We learnt about the legal side of things, all the practical elements and we had a week of shadowing other carers. They said to me, 'you usually have a week but if you want more you can have more'." Another staff member commented, "The training was fantastic, very thorough. I sat my entire training before being allowed to go out."

Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular refresher training in all key subjects and were encouraged to participate in additional training courses offered. For example, the registered manager told us about extra courses that some staff had recently completed in Parkinsons Disease and sepsis. A staff member commented, "The training is really good and we are always offered extra. Even when I started, I had access to lots of courses, which I thought was great that they were prepared to allow us to do extended courses outside what was essential. I did sepsis awareness, which was new to me and bereavement."

Staff were supported through 'spot checks', which involved senior staff observing care staff whilst they were providing care. Observations were recorded and fed back to staff to allow them to learn and improve their practice. A staff member told us, "I had [a spot check] to sign off my medication administration. They watched how I was working, that was before I went out by myself." Observations also fed into staff supervisions. These measures ensured staff had the skills, knowledge and experience to deliver effective care and support. Although we found that staff supervisions did not always take place in line with the regular timeframe as expected by the provider, all staff we spoke with felt fully supported by the registered manager and senior team in the office. One staff member commented, "I don't know how regular [supervisions] are, but we have them. We have supervisions in the office where they ask us loads of questions and you can talk about anything. We also have seniors who come out in the community to observe us."

Staff worked together as a team for the benefit of the people they supported. Staff were free to come and go in the office at any time to discuss matters. However, for the distribution of group messages, a system was in place to inform staff instantly of updates and information, which was sent to their mobile phones. Staff were

regularly informed of any updates or changes to people's plan of care, in addition to any changes within the general operations of the service. One staff member said, "The communication is good if there have been any changes with people's medicines, or if a GP has been out to see them. They [office staff] will let you know and communicate it to the team."

People were supported to maintain good health and had access to appropriate healthcare services when required. Where concerns were noted in people's health, we saw that professionals, including doctors and district nurses, were consulted appropriately and in a timely manner. For example, we saw a report form stating that where signs of a potential pressure injury were noticed by a staff member, this had been raised with a district nurse, who made an appointment with the person to provide appropriate care. On another occasion, the service made contact with a physiotherapy team to support a person with their mobility needs. Staff worked in partnership with the physiotherapy team to follow a plan of support and we saw that the person was now no longer receiving additional support from the physiotherapist. People and their relatives told us they were confident that staff would respond appropriately if they felt unwell. One person commented "Yes they are good as gold. They know if I'm not feeling so bright." A relative said, "They did that the other day, [my relative] fell out of bed and I hadn't realised. One of the carers realised and called an ambulance. [The staff member] came back afterwards and made sure everything was OK, I'd say that was beyond the call of duty."

Most people did not need support with eating and drinking, however some people needed support with preparing meals and these needs were met appropriately. One person said, "They always ask what I want for my breakfast and will do anything that I want. They always check it's OK afterwards too." People's care plans contained specific information about people's nutrition and hydration needs, including their likes, dislikes and preferences of how their liked their food cooked and served.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the Act. At the time of the inspection, all people using the service had the capacity to make decisions about their care and support, however the registered manager described the process which they would take if a person did not have capacity to make a decision. This ensured that people's rights were protected and decisions made were done so appropriately and in their best interest. Staff demonstrated a good understanding of the principles surrounding the Mental Capacity Act 2005 and how to apply this in everyday practice.

People were in control of their care and staff sought people's consent prior to providing or supporting people with their personal care. One person commented, "Yes, they do [ask consent]. They're courteous." Appropriate consent forms were in place in people's care plans, which had been signed by the person to agree to aspects of their care and support, such as sharing information with other professionals.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Comments from people and their relatives about the staff included, "They're probably some of the best carers I've dealt with over the years. They are very kind and considerate"; "They are friendly and welcoming" , "The carers are lovely, caring people and very good at their job" and, "They are competent and friendly. They have a chat with [my relative]. They're very nice."

Staff had developed positive relationships with the people they supported and spoke about them with genuine affection. One staff member said, "I love this job, the service users are beautiful people, they are so lovely." People and their relatives described the caring nature of staff. One person said, "I have lovely carers, it's easier to say 'what don't they do for me' rather than what do they do. Everyone is so kind and happy all the time, I can't do without them." A relative commented, "I can honestly say the [staff] we have had, have been brilliant caring staff, they brighten the day up. It's not easy [having support from a care agency] but they are very thoughtful and gentle. Whatever [my relative] wants, they do it with good grace."

People's care plans contained an "about me" section, which provided information about their background, life history, family and friends, interests, hobbies and what was important to them. Information like this allowed staff to get to know the people they were supporting and provided them with topics of conversation to build engaging and positive relationships with people. However, we identified that information about people's religious, cultural and diversity needs had not been recorded within their care plan. We discussed this with the registered manager who explained that people's faith needs were explored and addressed during initial assessments and if required, appropriate support would be given to ensure people maintained their cultural needs.

Staff were considerate of protecting people's dignity. They described the actions they would take to ensure that people's privacy was upheld whilst delivering personal care, such as pulling curtains and covering people with a towel. People and their relatives confirmed that staff respected their dignity. One person said, 'Yes, they close the door and pull the curtains. They will leave me in the shower if I want, or they stay. They cover me with a towel, it's all done quite nicely." A relative told us, "Definitely, they are [respectful of people's privacy]. They are careful about that. If there's anyone here, they tell them to leave the room if [my relative] is getting changed."

Staff respected and promoted people's independence by encouraging them to do as much as possible for themselves. One person told us, "[They encourage me] in the best possible way. I wash myself as much as possible." People's care plans contained guidance for staff which was reflective of the emphasis to ensure people remained as independent as they could be with the skills they had. For example, one person's care plan explained which areas of their body they were able to wash independently and which areas they needed staff to support them with.

People's preferences were considered over the staff that supported them with personal care. Where people had expressed that they did not wish to have a particular gender of staff member, this was respected and

adhered too. One person commented, "I have male and female carers, I was offered a choice and I don't have any problems. In fact, the man that comes out to me is very good indeed. They are always friendly and making me laugh, it takes away any embarrassment." Office staff used a matching system when allocating staff rotas to ensures that a member of staff would not be allocated automatically to a care call, against the person's preference.

Guinness Care At Home worked with people's friends and families to enable them to also feel supported by the service. The registered manager told us about a recent workshop they had held with people's relatives, to enable them to have access to a network of support and help them better understand dementia as a condition. The group had proved successful and evaluation forms described how people's friends and families had benefited from the experience to enable them to support their loved one more effectively. The registered manager told us they planned to continue the dementia groups on a regular basis throughout the year.

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want.

People's care plans and other personal information were kept confidential to ensure only people who were authorised could view them. People's information was stored securely at the office in a paper format and in an electronic format.

Requires Improvement

Is the service responsive?

Our findings

People were not always given choice and control in how their care and support was delivered. People did not always receive care from a regular team of care staff. One person said, "There is lots of different [staff], so there's no continuity which is a shame because you don't get the chance to build a relationship with them" and another person told us, "They send too many different [staff members]." A relative told us, "There's too many different carers come, they don't know [my relative's] history and don't read the care plan, so [my relative] ends up having to tell them what's what." Office staff produced a weekly rota for each person's care calls, which was then sent to people. This allowed people to know which staff member was due to complete a particular care call. However, we found that this often changed and people were not informed in a timely manner. One person said, "I get a rota each week of who's coming but it's not always followed, probably because of sickness or holiday. No one rings to tell you if it's going to be someone different." Another person said, "They alter the times without telling you. They never stick to the rota. I know that's not always possible if someone's sick or something, but you never know when they're coming."

People's care and support needs were considered carefully at their initial assessment before they started using the service, to ensure they could be met appropriately. People and where relevant, their relatives, were involved in the planning and delivery of care. One person said, "When my care plan was first set up, they came out to see me and spent a long time with me talking through what help I needed." A relative told us, "We were involved in the setting up of the care plan and everything was talked through with us at the beginning." As part of the assessment process, information was collected to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels.

People's care plans were developed to take account of the outcomes to be achieved in each aspect of people's care, such as health and wellbeing, personal care and mobility. Care plans were centred on the needs of each person and included information about their medical history, their preferred daily routine and how they wished to receive care and support. For example, one section of a person's care plan described their morning routine and outlined clear step by step information about where the person would usually be on staff arrival and the order in which they wished to receive each aspect of their personal care to start the day.

People's care plans and associated documentation were not always reviewed in a consistent manner, or in line with the time frame as set out by the provider. However, the registered manager explained that a new process of carrying out regular reviews had recently been implemented and we saw a schedule of upcoming reviews for the next couple of months to ensure all people's care plans and associated documentation were up to date.

At the time of the inspection, no one was receiving end of life care, however we found that people's care plans did not contain information regarding people's end of life wishes and preferences. We discussed this with the registered manager, who provided us with assurances that should people's health deteriorate, their wishes and preferences would be discussed with appropriate people in the person's life. Furthermore, staff

had received training to ensure people receive responsive and dignified end of life care.

One person said, "I do get choice over meals. I have things in the fridge or the freezer and I ask them to tell me what there is and I make the decision." Another person said, "On the whole the carers are very good, they listen to you and are considerate of you." Staff were aware of the importance of ensuring that people were offered choice and gave examples of how they did this in practice, such as letting people choose to stay in bed for a longer time.

People's individual communication needs were considered during their initial assessment with the service to ensure they received information in a way that they understood. The registered manager explained where people were not able to easily read their care plans or other care documents due to a visual impairment, information was available in larger print or on coloured paper. Other people had raised their preference to be contacted a certain way, such as by text, email or phone.

Arrangements were in place to deal with complaints and investigate them thoroughly. Information about how to make a complaint was available in people's home file to use if required. People and their relatives told us they felt able to raise concerns; one person said, "I'd speak to the office, but I can't imagine that ever happening" We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. The registered manager described how they used complaints to help identify learning and to improve the service.

Requires Improvement

Is the service well-led?

Our findings

People were not always confident in the management and leadership of the service. People's comments included, "The management side of the service isn't managing very well", "I think it is well run, but there's something not working" and "No, it never changes. Nothing gets any better." During the inspection, we identified some areas for improvement.

A quality assurance process was in place, which included regular audits carried out by the registered manager and a quality audit procedure completed by a compliance representative of the provider. We looked at records of a recent compliance audit that had been completed, which highlighted specific areas for improvement alongside a clear action plan. However, audit processes in place had not identified the issues raised during the inspection in relation to people's MAR charts, risk assessments, staff knowledge of people's care plans, timeliness and consistency of people's care calls and office staff communication.

The failure to ensure effective systems and processes were in place to assess, monitor and improve the quality and safety of the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager described the values of the service as those of being customer focused, transparent and supportive of service users and staff members. However, following the issues raised during the inspection, we found this was not reflected in the delivery of people's care and support.

There were good working relationships with external professionals and the provider notified CQC of all significant events. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred.

Feedback about the service was sought from people and their relatives through an annual survey carried out by an external organisation. This survey was sent nationally to all people using one of the multiple service's run by the provider, which meant that the results of the survey could not be easily identified to each individual service. In order to obtain specific feedback about Guinness Care at Home Hampshire, the registered manager completed regular spot check surveys with people, which focused on specific areas of the care and support they received.

A staff survey was sent out annually and staff meetings were held regularly, which allowed staff to discuss particular areas of the service with their colleagues and stay up to date with important changes and updates. We looked at minutes of recent staff meetings that had taken place, which showed areas of discussion such as training, medicine procedures, policy updates and PPE reminders. Staff were also given handouts to regularly refresh their knowledge, such as MCA aid memoirs, a falls and incidents pack and information about promoting people's dignity.

Staff were recognised for doing a good job or where they had received positive feedback from the people they supported. For example, we saw a copy of a staff member's supervision record, which documented the

feedback received about them from several people. The registered manager told us about the importance of passing on compliments to staff straight away, to build their confidence and sense of wellbeing. Staff told us they felt valued in their job role and would recommend working at the service to a friend.

The registered manager was supported by a representative of the provider, who visited the office regularly. They said, "[The provider's representative] are really supportive and always on the end of the phone." The registered manager attended regular meetings alongside other service managers registered under the same provider, to discuss current issues in the care sector and share best practice. The registered manager said, "It's useful to find out what different areas are doing and I can make valuable links with other managers."

Policies and procedures viewed were appropriate for the type and nature of the service. Where new or changes to policies and legislation were implemented, this was distributed to staff during team meetings and supervisions, to ensure their knowledge and understanding was updated accordingly. The registered manager said, "Guinness as a provider are very hot on changes to policies and procedures. They are constantly promoting good practice."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The provider had failed to ensure effective systems and processes were in place to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The provider had failed to deploy a sufficient number of staff to meet people's care needs.