First Choice Home Care Ltd

First Choice Home Care (Wymondham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection that took place on 17 May 2017.

First Choice Home Care (Wymondham) is a service that provides personal care to people in their own homes. At the time of the inspection, 164 people were receiving support from the service.

There was a registered manager working for the service. 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 and associated Regulations about how the service is run.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that risks to people's safety had been assessed appropriately. Although staff knew how to keep people safe whom they saw regularly, they sometimes supported people who they were not familiar with. They therefore relied on accurate information about these people's needs being made available to them but this was not always the case. This placed people at risk of unsafe care.

Although the provider was looking to make a number of improvements in their governance and quality monitoring systems, some of their current processes were not effective at driving improvement within the service.

You can see what action we told the provider to take at the back of the full version of the report. We have also made a recommendation that the provider seeks relevant guidance on how to improve staff knowledge in relation to applying the principles of the Mental Capacity Act 2005 to their practice.

There were enough staff to meet people's needs and they knew how to protect people from the risk of abuse. The staff were kind and caring and treated people with dignity and respect.

Staff had received training to help them provide people with effective care. However, some shortfalls were noted in relation to the staff's knowledge regarding how to provide good care to people living with dementia and where people lacked capacity to make their own decisions. The provider was aware of this and had recently sourced further training for staff in these areas.

The current systems in place to make sure people received their medicines when they needed them were not robust. The medicine records we looked at showed people may not have received their medicines as intended by the person who had prescribed them.

People who needed support to eat and drink as part of their care package received this and they were also helped to maintain their health where this was needed. People were involved in making decisions about

their own care and were offered choice.

People's care needs had been assessed but these were not always being fully met. The staff usually arrived on time to provide people with the care they required but they did not always stay for the required length of time.

People received information about how to complain to the service. Any complaints or concerns made were usually dealt with but there was no process in place to ensure verbal complaints were acted upon.

The staff were happy working for the service. Their morale was good and there was an open culture where they were able to raise concerns without fear of reprisal. Leadership was in place to provide staff with advice and guidance when needed.

We have made a recommendation that the provider seeks guidance and training for staff on the Mental Capacity Act 2015.

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 consistently safe.

Risks to people's safety had not always been assessed or reviewed when needed.

The systems in place to ensure people received their medicines when they needed them required improving.

Staff were aware of how to protect people from the risk of abuse.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training in a number of different subjects but their understanding of the training had not been robustly tested to ensure they consistently provided people with effective care.

People's consent was sought but improvements were required in relation to staff understanding of the Mental Capacity Act 2005. This was to ensure consent was received in line with relevant legislation where a person could not consent to care themselves.

Where it was part of their care package, people received support to eat and drink enough to meet their needs and support to maintain their health.

Is the service caring?

Good

The service was caring.

The staff were kind and caring and treated people with dignity and respect.

People were able to make decisions about their care, with support from their relatives if they wanted this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs and most of their preferences had been assessed. Some people's needs were being met but not all.

People knew how to raise complaints but did not always feel that the service improved in response to these. The systems in place to learn from complaints did not capture all people's concerns to help the provider drive improvement in the quality of care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The current systems in place were not all effective at driving improvement in the service to ensure people received good quality and safe care.

Staff were happy working for the service and leadership was in place to provide them with guidance and direction.

First Choice Home Care (Wymondham)

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.

This inspection took place on 17 May 2017 and was announced. The provider was given over 24 hours' notice before we visited the office because the service provides care to people within their own homes. The provider and staff operated from a central office and we needed to be sure that they would be on the premises so we could speak with them during the inspection.

The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspectors visited the provider's office and the experts by experience gathered feedback from people and their relatives over the telephone.

Prior to the inspection, the provider had 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 also reviewed information we held about the service. This including looking at notifications the service had sent to us. Services have to, by law, send us certain information in relation to incidents or accidents that occur. Before our inspection, six staff and 12 people using the service gave us their views in surveys we sent to them.

During this inspection, we spoke with six people who used the service and six relatives of people who received care from First Choice Home Care (Wymondham). We also spoke with seven staff, the registered manager and a director of the provider.

We looked at the care records and risk assessments of seven people who used the service, four of which we reviewed in detail. We also reviewed four staff recruitment records and information in relation to staff training. We looked at how the provider monitored the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

Risks to people's safety had not always been assessed or reviewed in response to incidents that had taken place, to ensure that people received the appropriate level of care.

The staff we spoke with were knowledgeable about the action they needed to take to reduce risks to people's safety. However, there was a lack of guidance for them to follow within people's care records. This was a concern as some of the staff told us they were asked to provide care to people they were not familiar with when their usual carer was not working. Some staff told us they relied on the information that was in people's care records to guide them on the care people needed. The registered manager confirmed that the risk assessments we viewed in the office were copies of the information staff could refer to in people's homes.

The staff supported one person to move with the use of a hoist. The person's moving and handling risk assessment had been completed in respect of this but had been completed incorrectly. It stated that the person did not need any assistance to move. Therefore, no actions had been documented within this person's risk assessment to tell staff how to do this safely. Another person had been identified as requiring assistance from staff to move out of their bed or from a chair. Again, no information had been recorded to advise staff on how to do this safely or how to ensure the person, who had left sided weakness, should be positioned to ensure they were comfortable.

The staff had assessed another person as being at moderate risk of developing a pressure sore. They had not documented any actions in relation to what needed to be done to reduce this risk. Another person's pressure care risk assessment stated they were not at risk of developing a pressure sore. However, their care and support plan indicated that they had reduced mobility following a stroke which would indicate they were at risk. A staff member we spoke with told us the person required a specialist cushion to be in place when they sat in a chair, but this information was not documented within their care record.

For one person, we saw from their original NHS assessment dated September 2015, that the person could become upset and distressed which could lead to them harming themselves or others. An incident had occurred in August 2016 where this person had harmed a member of staff. We asked the registered manager for evidence that this incident had been fully investigated and action taken to help staff manage this situation. They were unable to provide us with this information and said that this person no longer demonstrated these behaviours. However, a member of staff who had provided care to this person told us this person continued to occasionally become distressed when they provided them with personal care. They said they tried to calm the person but were not sure of the best way to deal with this situation. There was no risk assessment in place in relation to this or information to guide staff on how to support the person safely.

For two people, the question in relation to their falls history had not been completed on their falls risk assessment. The conclusion of the risk assessment was that they required a referral to a specialist falls team but this had not been completed. There were no actions noted within the risk assessment for staff to follow regarding how to reduce this risk. One person had been noted as having a fear of falling. Again there was

nothing to suggest how staff could support the person with this. This person told us they did not feel safe with some staff when they were assisting them to move and a staff member we spoke with confirmed this. They said that the person often became distressed and upset when they assisted them to move due to their lack of confidence in this area.

It had been assessed that one person required two staff to support them on all visits. However, we found on two occasions in April 2017, that only one staff member had provided care to the person. We spoke with the registered manager about this. They told us that in this circumstance, the person's relative would help with moving the person. They agreed however, that this should not occur and that two care staff should always provide care. This was a risk to the person, their relative and the staff member's safety.

One person had been assessed in December 2016 as being able to take their own medicines. This was despite the original referral to the service from the local authority stating that the person required prompting to take their medicines. Records showed that in March 2017, the staff had alerted the office that the person had not taken their medicines. This had been reported to the on-call staff. We spoke with the registered manager about this who did not provide any evidence to show that this incident had been followed up.

We spoke with the staff about this concern. They told us the person did not have the capacity to take their own medicines and on occasions, they had found that the person had not taken them. The staff said that the person's relative was responsible for ensuring this person took their medicines. However, the staff were also supporting this relative to take their own medicines safely. We were therefore concerned that the person's risk in relation to taking their medicines safely for their health and welfare, had not been re-assessed when there had been cause to do so. We spoke with the registered manager about our concern and they agreed to immediately investigate it.

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

All four people or relatives who we talked to about their medicines told us they received them when they needed them. One person told us, "They give me my tablets and they always do so. They are on time with them." Another person said, "They always give me my tablets." A relative told us, "They are very reliable. If I need them to prompt her with her medication then I can trust them to do that."

All of the staff we spoke with told us they had received training in how to give people their medicines safely. They also said that their competency to do this had been assessed recently. The staff files we looked at confirmed this. Staff told us they always checked people's medicine administration records (MAR) before they gave the person their medicines. This was not only to ensure they were giving the person the correct medicine but also to check that the person had been given their medicines correctly by the previous staff member who had visited them. They did this by checking to see if that staff member had signed the MAR to say the medicine had been given. However, of the three MAR we checked, we found gaps in all of them. We also found significant gaps in another person's prescribed cream chart. This indicated that these people may not have received their medicines as prescribed. We also found that a number of the MAR were handwritten. There was not always information to show who had completed the record and whether they had been checked to ensure this information was correct. It is good practice to do this.

The registered manager told us they monitored that people had received their medicines by auditing their MAR each month. However, all of the MAR we looked at had not been audited within this timeframe. They were all in relation to medicines given prior to 25 February 2017 but had only been audited in May 2017. This meant that issues with people's medicines were not being identified in a timely manner. We found that

improvements were required in the way people's medicines were monitored so the provider could ensure that people were receiving their medicines correctly.

The checks the provider made prior to recruiting staff to the service needed improving. All four of the staff records we looked at showed that their full employment history had not been explored. All of the other required checks were in place. This included obtaining references from previous employers and a Disclosure and Barring Service check. These enabled the provider to ascertain whether the potential staff member was of good character, had any criminal convictions or had been barred from working within the care industry.

Five of the six people we spoke with told us they felt safe when the staff provided them with care. All of the relatives said they felt their family member was safe. One person told us, "I feel safe with them." Another person said, "I feel safe and have no worries or concerns really." A relative told us, "[Family member] is always moved with care and safely." Another relative said, "The care is 100% safe and we have no concerns at all."

All of the staff we spoke with told us they understood how to reduce the risk of people experiencing abuse. They were clear about the different types of abuse that people could be exposed to and how to report any concerns they had. We saw that any concerns raised with the registered manager had been reported to the appropriate authorities and investigated. Action if required, had been taken to reduce the risk of the person or other people experiencing abuse.

All of the people and relatives we spoke with told us they felt there were enough staff to meet their needs. They said they had not experienced any missed calls. Eleven of the twelve people and relatives we spoke with said that staff stayed for the correct amount of time to provide them with the care they required. One person told us, "The staff stay for the full amount of time." A relative told us, "They stay for the full time." Another relative said, "They stay for the full time and will sit and chat with him. They always provide complete care." However, one person said, "One or two will stay for the full time but some of the younger ones go after ten minutes."

All of the staff we spoke with told us they were able to spend the contracted amount of time with people. They told us they only left early if the person requested this. They also confirmed they had not missed any care visits.

The registered manager told us they were continually recruiting new staff but that there were currently enough to cover all the required care visits. They said that if needed, existing staff and the staff in the office covered any unplanned staff absence such as sickness but that this was not an issue. Missed and late calls were being monitored via an electronic system that had been introduced in March 2017. If a staff member did not activate the system to say they had arrived at a person's home within 30 minutes of the scheduled time, the system alerted the office staff. They confirmed they then took action to ensure the staff member had either attended the care visit or was on their way to do this.

Requires Improvement

Is the service effective?

Our findings

Of the five people and relatives that commented about staff competence to perform their role, four spoke positively about this. One person told us, "They seem trained." A relative told us, "They all seem to know what needs to be done." Another relative said, "They seem to be trained to do the job and new staff come and shadow the established staff." However another relative said, "I don't think they have adequate training in dementia care. They could benefit from attending a course. They don't always understand why [family member] is saying things."

Prior to the inspection, we had received three concerns that staff had not received sufficient training to enable them to provide people with effective care. Two of these concerns were directly in relation to staff understanding of dementia. We asked three care staff if they had received training in dementia care. All of them told us they could not recall receiving this but confirmed they were providing care to people who were living with this condition. They told us they felt this sort of training would be useful to help them provide these people with more effective care.

The individual staff training records we looked at did not contain any evidence in the form of certification, to show that staff had received this training. However, the registered manager told us that this subject was covered during the staff induction training but that they had recognised improvements were needed in relation to training within dementia care. Therefore, a new member of staff had recently been recruited to the team whose specific role was to train and coach staff. One area in which they were qualified was in respect of dementia training. The registered manager told us they had plans in place to provide all staff with further training in dementia and for some of them to become dementia coaches to help improve staff knowledge.

All of the staff reported that the training they received in other areas was good. They had completed training in a number of different subjects including but not limited to, supporting people to move, infection control, safeguarding adults and first aid. The staff confirmed that if they required training in other areas to meet people's needs such as stoma and catheter care, that this was provided. Staff told us their competency to perform their role effectively had been regularly assessed and that feedback in respect of this had been received. This they said, helped them improve the quality of care they provided to people.

The induction training that staff received had recently been reviewed and changed. New staff now received five days of initial training instead of four and more classroom based training was completed. The training that staff received reflected that of the Care Certificate. This is a recognised qualification in Health and Social Care that represents best practice training during a new staff member's induction period. The staff member then spent some time with an experienced member of staff before being signed off as being competent by a senior member of staff. We spoke with one member of staff who had recently completed this training. They told us it had provided them with the skills they required to provide people with effective care.

During the inspection, we found issues with the completion of medicine records, risk assessments and

assessments of people's capacity. Staff knowledge in relation to dementia and the Mental Capacity Act 2005 needed improving. We have therefore concluded that staff were receiving training in the relevant subjects, but that their learning within all of these areas had not been sufficiently assessed to enable them to consistently provide people with effective care. Improvements are therefore required within this area.

All of the people and relatives we spoke with about consent, told us this was requested by the staff before they performed a task. One person told us, "They always ask my consent when they do things." Another person said, "They always ask what I want and provide everything I need."

The staff told us they supported some people who were unable to make their own decisions. Therefore they had to work within the principles of the Mental Capacity Act 2005 (MCA). The 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.

The staff we spoke with had a mixed knowledge about the MCA and its associated principles. All staff understood the importance of providing people with choice and some staff told us how they did this. For example, showing people different clothes they could wear or food they could eat. However, most were not clear about the MCA and how it impacted on their daily practice. Some staff told us they did not think they had received training in this area. The registered manager told us that this training had been completed during staff induction training. However, the staff records we looked at did not contain any certificated evidence to show this had been the case.

People's capacity to consent to their care had been assessed when they started using the service. This was decision specific and detailed the decisions people were able to consent to. However, we found that out of the four people's care records we looked at in detail, one person's capacity assessment had not been reviewed since they started using the service. Originally they had been deemed as having capacity to take their own medicines but staff told us this was no longer the case. We had received a concern prior to the inspection from a relative who said the service had assessed their relative as having capacity to take their medicines. However, they subsequently had not taken them. We spoke with the registered manager about this. They told us that the staff who were responsible for performing these assessments had recently received further training in the matter. They were confident this would improve the accuracy of people's capacity assessments.

Information in relation to who could legally consent on behalf of the person in their best interests, if they lacked capacity, had been assessed. This is important so staff know who can legally make decisions in relation to a person's care if the person cannot do this themselves. To enable a person to do this on another's behalf, they have to hold the relevant Lasting Power of Attorney (LPA) which in this case would be for health and welfare. However, we found the information in relation to LPAs had not always been completed correctly. For one person, it had been recorded they had a LPA but their details had not been completed. For another person, it was noted that two of their relatives had LPA but it had not been documented which sort they held. The registered manager told us that the paperwork in relation to the LPA was checked at the time of assessment and a copy held within the care record. However, there were no copies held in the care records we looked at.

We recommend the provider seeks guidance and training for staff on the principles of the MCA when providing care to people who cannot consent to their own care.

People who were receiving support to eat and drink as part of their care package, told us this was done to their satisfaction. One person told us, "They help with meals and I always tell them what I want and then they prepare it." A relative said, "If I need them to prepare any food they will. The staff are good with handwashing and do wear aprons and gloves."

The staff told us they knew people's likes and dislikes in relation to food and drink and that they made every effort to prepare food in a way people wanted this to be done. People's risk of not eating and drinking enough had been assessed and whether they were at risk of choking. Information was in place to guide staff on how to prepare people's meals and whether they needed to be vigilant in relation to people's eating and drinking. Staff told us they often left people with snacks and drinks before they left the person. Some staff said they completed food and fluid charts when required so the person's intake could be monitored. They were all clear that any concerns would be reported to the main office.

Most of the people and relatives we spoke with were responsible for arranging their/their family member's own health care. However, the staff told us they often contacted the local GP on behalf of a person if this was needed. They said other healthcare professionals such as occupational therapists, dieticians and dentists were also contacted. Staff also told us how on occasions, they had contacted the emergency services for people. Some records we viewed showed that professionals had been contacted when needed. We were therefore satisfied that people were supported with their healthcare needs.

Good

Is the service caring?

Our findings

All of the people and relatives we spoke with told us that the staff were kind, caring and polite. One person told us, "I like my carers. They are polite and treat me with respect." Another person said, "I like the staff, we get on well. They chat to me." One relative told us, "She gets on well with the staff and they treat her well. They are polite with her and not brash at all. They are good at chatting with her and treating her with respect. They always leave things tidy." Another relative said, "[Family member] has got to know them and seems to like the care staff."

Eight of the 11 people and relatives we spoke with about seeing familiar staff each day, told us they saw the same staff to help them build caring relationships with them. One person told us, "They have got to know me and I have got to know them too." A relative told us, "We have three or four different carers but they tend to be the same staff who come. They are getting to know [family member] now." Another relative said, "We have the same staff who come." However, three people told us this was an issue for them. One person told us, "It is rather annoying and upsetting for me as I don't get the same people." A relative said, "There isn't a lot of consistency in the staff, they seem to change before they have got to know [family member]."

All of the staff told us they enjoyed their job and felt proud working in the care industry as they wanted to make a difference to people's lives. They demonstrated they knew the people they provided care to well. However, they did say that on occasions they had to assist people who were not familiar to them if they were covering unplanned sickness or holidays. They said they found it difficult to build relationships with these people. The records we looked at in relation to people's care showed that most of them received regular carers. The registered manager told us they were aware that this was an issue for some people and therefore, had recently implemented a restructure of the service into smaller geographical areas to help improve this.

Some staff told us how they had completed extra tasks for people that were outside of their daily remit. A relative we spoke with confirmed this when they told us, "They are always courteous and will often do little extras to help us out." One staff member said they had taken the time to collect some compost from a local garden centre for one person. The staff member explained they knew it was important for the person to have plants in their garden and so had done this for them. Another staff member said they had recently got a person their favourite meal of fish and chips in their own time. The registered manager told us they often sent cards to people and/or relatives in respect of birthdays or in condolence.

The service supported people to express their views and be involved in making decisions about their care. People and relatives told us that this was the case. One person told us, "I have a care plan which they come and check when they visit." A relative said, "We drew up a care plan when we started with them and it covers all of [family member's} needs." A further relative told us, "They came to do a care plan for us initially and it has been reviewed recently."

The staff we spoke with said they always offered people choice and respected people's decisions. People and/or their relatives were involved in the planning of their care when they started to use the agency. All of

the care records we looked at showed that people had recently been involved in a full review of their care. The registered manager told us that a 'service user' guide was given to people and relatives if necessary, when people first started using the service. This detailed information such as contact numbers of the office, the companies' objectives and how care would be provided. The registered manager told us this information could be provided in various formats such as large print or Braille if required.

All but one of the people and relatives we spoke with told us staff treated them or their family member with dignity and respect and upheld their privacy. One person told us, "I like most of the staff and there is no rudeness or bad attitudes but some of the youngsters do tend to rush off. They are respectful to me and my home." A relative said, "The staff are alright but age is a factor as they are so young. They are polite though, nice girls. They are very considerate with [family members] privacy and dignity."

The staff told us how they protected people's dignity and privacy such as closing doors and curtains or covering people whilst supporting them with personal care. They were clear about the importance of maintaining this for people.

Requires Improvement

Is the service responsive?

Our findings

Most of the people and relatives we spoke with told us the care provided met their individual needs and that the service was responsive to their needs. One person told us, "My care covers all that I need." A relative said, "There are no gaps in [family member's] care. We have really good care." Another relative told us, "[Family member] really feels the cold in a morning so often they will leave her hair wash until later in the day. They adapt to her needs. The call times suit us and if I go out I can trust them to be there on time and deliver the care." However, we received mixed views from people as to whether the times of the care visits met their individual preference.

One person told us, "The carers are usually on time." Another person said, "I am a stickler for time and although some come early and some come a bit late it causes no issues." A relative said, "They turn up on time and we know who is coming which really helps." However, another relative told us, "They can be late, in fact they are never on time. Mornings in particular are a problem as they can be up to 45 minutes late. But they are all very good. The care is good." A further relative said, "As far as I am concerned the carers are excellent. Our call time was agreed at 10am but they come at 9am mostly which is difficult as I have to get up early for them. They are brilliant with [family member] but it is just a bit too early for us." The staff told us they could sometimes be late for care visits but said this had improved and did not happen very often.

When we checked people's care records we saw that some of their preferences in relation to how they wanted to be cared for had been assessed. This included the gender of carer they preferred and what their individual goals and wishes were. However, their preferred care visit times had not been recorded. The registered manager told us these were agreed with people but had not been captured in the initial assessment of their needs. Two of the four people's records we looked at for April 2017 showed that care visit calls were either inconsistent or not line with their preference. One person had calls earlier in the morning than they told us they preferred although the majority of these had been within 30 minutes of their preferred time. Another person's morning care visits had taken place at inconsistent times ranging from 6.45am to 9.55am.

We also found that staff had not always stayed the correct length of time with two of the four people whose records we checked in detail. For one person, we looked at the times of twenty visits over five days in May 2017. Their care record said they required four visits per day each of 60 minutes. We found that 14 visits fell short of the contracted 60 minutes by 15 minutes or more. For another person, their evening visit which should have been 90 minutes was regularly only 60 minutes. One of these people told us their needs were not being fully met. The registered manager told us they were aware of the above issues and were currently working on a project to re-organise staff in geographical areas which they said would improve this and give staff sufficient time between visits.

All of the people's care records we looked at demonstrated that their needs had been regularly reviewed. The staff told us they received information in relation to this via their phones or by email so they could keep up to date with any changes. They said they felt they could provide people with care based on their individual needs. One staff member said that one person enjoyed making their own bed so they encouraged

them to do that. They also said they could meet their preferences in relation to bathing. However, for two of the four people whose care we looked at, changes had not always been made to the care they received in relation to their changing needs.

One person told us how they were seeing a physiotherapist to help them with their mobility and arm function. The staff told us they were aware of this but said they did not encourage this person to walk. Rather they used a commode to move them around the home when providing them with personal care. The staff said they would like to help this person with exercises to increase their mobility but that they did not have time to do this. The registered manager told us that staff were helping this person complete arm exercises but the staff we spoke with said they were not doing this. We saw that the person had had a review of their care in early May 2017. They had stated that the care did not meet their current needs but no changes to their care had been made. It was not noted within their care record the importance to this person to be supported with their mobility and movement to aid their independence.

Another person had been found to not be taking their medicines on occasions. However, their care needs had not been re-assessed in response to this information to ensure they received the care they required. This person's care record also lacked information in relation to their diabetes. There was no information in place to guide staff on what to look out for should this person be unwell or what action to take should they become hypo or hyperglycaemic.

Two of the people we spoke with told us that sometimes, they found it difficult to communicate their needs and wishes to some staff. They said this concerned them. One person told us, "There can be a language problems." Another person said, "I ended up having to draw things to explain, like a mushroom when I wanted mushrooms with my dinner. Carers should have speech and understanding in order to be a carer."

We spoke with the registered manager about their recruitment procedures and support they gave to staff whose first language was not English. They told us they did not assess staff's ability to verbally and write English at interview. They said they supported these staff to improve their English by asking them to complete the Care Certificate. However, they did not support the staff specifically to improve their English language skills or monitor this.

Improvements are required to ensure that care is being planned and delivered effectively to meet people's individual needs.

The staff told us they were aware of the risk of people experiencing social isolation. They said they encouraged people into the community and were able to signpost people to local events. One staff member told us how they had helped one person access community services which had had a positive impact on their lives.

People were encouraged to raise concerns through regular reviews of their care which occurred either face to face or over the telephone. All of the people and relatives we spoke with told us they knew how to make a complaint if they needed to and that they could get hold of the office. One person told us, "Although I haven't needed to complain, I know how to and feel that I could talk to the office if I wanted to." Another person said, "I have never complained." A relative said, "I would be happy to raise any concerns with the office if I had any but I haven't needed to complain." However, five of the ten we spoke with about the responsiveness of the service in relation to concerns raised, told us they did not think the service was very good at this.

One person told us, "If I had an issue I would talk to the carers about it, I probably wouldn't bother ringing

the office. I have asked the carers about a rota but I still don't get one." Another person said, "I have emailed them several times and they don't respond. I have been overcharged too. When I phone them they have been okay but originally I didn't have a telephone number." A relative told us, "I have spoken to them on many occasions about call times but nothing seems to be done about it." Another relative said, "I have spoken to the office about the young carer a month ago now and they haven't done anything. Nothing changes if you have an issue. No solution is offered."

People and relatives were given information on how to complain once the care commenced. The information was appropriate and gave guidance to people on how they could escalate their complaint if they were not happy with the initial response they received.

We looked at the people's records who had told us they had raised a concern. We found evidence that most of these had been looked into and that they had been acted upon. For example, one person had requested the times of their care visits to be changed and this had been honoured. They had also asked for some staff not to attend their calls and again, this had been put in place. However, another person had continually raised in quality monitoring visits that the care was not meeting their needs. This has been raised with the service in December 2016 and again in May 2017. It had not been recorded within their care record what action had been taken in response to this feedback. The registered manager showed us the form that should be completed to help them track people's concerns had been dealt with but this had not been done. The registered manager agreed to look into this person's concerns.

The service had received seven written complaints in the last 12 months. We saw that each of these had been investigated and dealt with by the registered manager. These had been analysed each month for patterns to help the provider improve the quality of care people received. However, verbal concerns had not been included within this analysis. This would give the provider a more robust view of people's concerns to help them learn from their complaints. Therefore, the current system in place requires improvement.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems for assessing and monitoring the quality and safety of care people received were not always effective.

The provider employed some staff who were responsible for monitoring the quality of care provided. They did this through spot checks of staff competence and performing a range of audits. We checked some of these audits and found they were not all effective at improving the quality of care people received

The care records we looked at contained a record of an audit that had recently taken place. This audit had been conducted to check that the appropriate information was contained within the care records in relation to people's current care needs and risks to their safety. However, although the audits said there were no issues, we found that some people's risk assessments lacked detail and/or were inaccurate which increased the risk of them receiving unsafe care. There were records to suggest that two people's needs had changed and that they may not have been being met but this had not been picked up during the audit and therefore, investigated.

Audits in respect of people receiving their medicines had been completed but they had not been completed each month as required by the provider. This meant that office staff not identifying any issues in a timely manner so that they could be dealt with effectively. The date of the medicine record that was being audited had not been recorded on the audit and the medicines that had been identified as being potentially missed had not been listed. The registered manager would therefore not be able to address the shortfalls raised. We also found gaps in a number of people's medicine records. This meant that a contemporaneous record of their care had not always been kept.

The information within the person's communication log, where staff recorded the care they had given to the person on a daily basis, had not been cross-referenced with any audit findings for their medicines. This was important to help the provider identify whether gaps in records was a recording issue or indicated the person had not received their medicines and required further investigation.

A check was in place to ensure that staff had completed the required employment checks before they started working for the service. However, we saw that these had stated that staff had full employment history in their staff files but we found this was not the case. The registered manager or provider would therefore not be aware that these needed further interrogation.

The registered manager told us that although an electronic system was in place to check that staff had completed people's care visits, another way they did this was to check people's communication logs regularly. We checked three people's communication logs that had recently been audited. Two of these indicated that two people may have had a missed care visit. The audit of these records had not identified this. The registered manager, on checking the electronic records, found that these people had not missed a visit but this had not been investigated until we found the issue.

We also found that the communication log for one person indicated they had only received care from one staff member instead of two on some occasions as was required. This again had not been picked up by the audit so it could be checked. It was recorded in the another person's communication log that on one day in March 2017, they had not taken their medicines and that his had been reported to the on-call. This had been identified as an issue on the audit but there was no evidence that action had been taken in response to this concern raised by staff. This had been a missed opportunity to ensure that the care provided to this person currently met their needs. Another person's communications log showed that staff did not always stay the right amount of time with them and that their calls were inconsistent. This again had not been identified as an issue in the audit.

There was no system in place to analyse people's verbal complaints or from incidents or accidents that had occurred. The registered manager told us that incidents and accidents were looked at and a record kept in people's care records but that they did not formally assess them for any patterns to help the service improve if required. The provider therefore did not have systems in place to learn from these. The system in place to support staff whose first language was not English was not robust to ensure they could communicate effectively.

The registered manager told us they had just started conducting their own audit of the service. The first one had been completed in May 2017. This audit covered certain areas such as the safety of the premises and complaints but it did not check that the current governance processes in place were being applied effectively. The registered manager told us they randomly checked the records of people and staff to see if the information within them was accurate or if audits being conducted were effective. The provider also told us they randomly checked the quality of care being provided. Both of these systems were not formalised or recorded. Neither the audits by the provider's representative nor those completed by the registered manager were robust in identifying the concerns that we found.

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

The registered manager and provider had identified that some areas of the quality of care they provided required improvement. They had therefore taken steps to do this. For example, they had assessed that they needed to improve training for some staff in dementia, risk assessment and care planning. They had therefore employed a specific individual with the prime responsibility of providing training to staff which included within these areas. This had either already occurred or was in the process of taking place. The registered manager had also identified that staff would benefit from training in end of life care which was being arranged.

The provider had recently employed staff to take on the role of quality officer and an electronic system had been introduced to monitor that staff were attending care calls. The registered manager told us that plans were in place to recruit a medication officer who would be responsible for medicines compliance. Therefore, the provider and registered manager had taken steps to improve the quality of care provided but the systems currently in place were not all effective at driving improvement.

Eight of the 11 people and relatives we spoke with about this subject told us they felt the service was well led. One relative was not sure and two said they did not think this was the case. One person told us, "I don't know who the manager is and I have never had to call them. I can't suggest any changes really but I do like the fact that they are always on time which I think is amazing." Another said, "Whenever I call they are always helpful. I know the manager. They always come so that is important to me." A relative said, "The best thing about the company is that you can always get in touch with someone. I would recommend them."

The registered manager was supported by the provider, a deputy manager, care co-ordinators, team leaders, senior carers and administration staff. All of the staff we spoke with told us they felt supported by this management team. They told us they were all approachable and open and they felt the current leadership at the service was good. Staff told us that the communication to them was good and that their morale was high. They felt engaged with the company and understood their individual roles and responsibilities. A newsletter was sent to them regularly to update them on important issues affecting the service. Staff meetings also took place on a regular basis so staff could discuss any concerns or issues they had.

The registered manager and staff engaged with the local community in fundraising events and supported local charities. Some of them had arranged to attend a local café in the area that was run for people living with dementia. This linked helped staff signpost people and their relatives to this service if they wanted to attend it.

The registered manager told us they kept their knowledge up to day by attending local forums and registered manager meetings so they could learn about best practice within the homecare sector.

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 Risks to people's safety had not always been assessed or action taken to mitigate these risks. Regulation 12, 1, 2 (a) and (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor the quality of care provide and mitigate risks to people's safety were not always effective. Contemporaneous records in relation to people's care had not always been kept. Feedback in relation to concerns raised was not always acted upon. 17, 1, 2 (a), (b), (c) and (e).