Nestor Primecare Services Limited

Allied Healthcare Liphook

Inspection report

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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

This inspection took place on the 26, 28 October and 1 November 2016 and was announced by giving the provider 48 hours' notice. We gave notice of this inspection to ensure the people we needed to speak with were available.

Allied Healthcare Liphook provides care and support to children, adults and older people living in their own homes in Surrey, Hampshire and West Sussex. Some people using the service were living with dementia or had learning disabilities or physical disabilities and complex care needs. At the time of our inspection the service was providing care and support to 91 people.

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

During our previous inspection of 28 and 29 July 2014 we found one breach of legal requirements in relation to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to Care and treatment. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replaced the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following the inspection the provider wrote and told us they planned to meet the requirements of this regulation by 1 May 2015. During this inspection we checked to see if the provider had completed their action plan to address the concerns we found. We found the provider had made improvements to meet the requirements of the regulation.

The provider had introduced a screening and assessment tool to assist staff to assess whether people had the mental capacity to make decisions about their care and treatment. We saw this was in use by staff who completed assessments and developed people's care plans. These staff had completed training in the Mental Capacity Act 2005 (MCA) and arrangements were in place for all staff to complete this training.

People told us they felt safe with the provider's staff and were cared for safely. Staff completed training in safeguarding people from abuse and knew how to raise any concerns. We saw that action was taken to report concerns to the local authority safeguarding team, however the provider did not always notify us of allegations of abuse. Providers are required to send us a statutory notification of any allegation of abuse so we can monitor the safety of the service people receive.

The provider had merged their services in Guildford and Liphook and both services were now managed from the Liphook branch. Key administrative staff and a number of care staff had left the service following the change resulting in a number of care staff vacancies. At the time of our inspection field care supervisors and care coordinators were also providing personal care to people to ensure people's care needs were met. This had resulted in some disruption to the organisation of people's care which some people told us had at times

been inconsistent and unreliable because staff were often late and they did not always know which staff would be coming and when. People we spoke with did not report they had experienced any harm due to these arrangements. Whilst the situation was improving the service needs to demonstrate that it can sustain an appropriate level of permanent staffing to enable them to meet people's needs consistently.

The management of people's medicines was not always safe. We found that risk management plans were not always robust enough to mitigate the risk to people from missed medicines. Where people used topical medicines (creams applied to the skin) staff had not always recorded when they had been applied and a body map was not always available to ensure staff knew where to apply the cream for people. We found some recording errors in the medicine administration records (MAR) for some people. The provider's monitoring arrangements of only auditing a proportion of the MARs every month meant that when errors occurred they could remain undetected for some months.

People's feedback about the management of the service was not consistently good and some people told us communication from management and office staff could be improved. Changes to the service had impacted on the ability of the registered manager to meet all the responsibilities of their role. People and their relatives told us they did not always feel the provider had responded appropriately to their complaints and concerns. Some complaints had not been investigated and responded to within the timescale set by the provider. Some people did not know how to make a complaint.

Incident reports showed that incidents such as missed calls had not always been investigated in a timely manner to identify the impact and the actions taken to mitigate any potential harm to the person and prevent a reoccurrence. This meant people could be at risk where incidents were not investigated and managed promptly. An action plan was in place to address the areas of improvement required. However, the service required more time to fully implement and sustain these improvements consistently into their practice.

People were asked for their views on the service by the provider. However it was not evident how this had always been used to make improvements to the service. Arrangements in place to seek people's feedback about the service face to face had not been consistently carried out. The registered manager was taking action to address this.

Risks to people were assessed and guidance on how to manage risks to people was available to guide staff. People had achieved positive outcomes such as improvements in their health from the care provided by staff to manage risks to their health and wellbeing. Staff used a screening tool to check people were safe and to identify any changes during their visits.

People spoke positively about the standard of care they received from the provider's staff. Care staff completed an induction and on-going training to ensure they remained competent in their role. Staff followed the guidance of the provider's clinical lead and other healthcare professionals as required to deliver safe and effective care.

People were supported with their nutrition and hydration needs. Staff were aware of people's preferences and choices for food and drinks and guidance was available to prompt staff when people may not be able to tell them about these.

People and their relatives told us staff were kind and caring. Staff we spoke with demonstrated they knew about people's individual needs. People's care plans included detailed visit summaries which ensured staff had the information available to meet people's needs in line with their decisions and wishes.

People's needs were assessed and used to develop comprehensive and personalised care plans. People and their relatives were involved in the review of their care plan on a regular basis. When people received support with their healthcare their care plan and care delivery was overseen by the provider's clinical lead to monitor and review progress.

Staff were supported to understand their role and responsibilities through regular supervision, appraisal and team meetings. Staff were recruited safely to protect people from the employment of unsuitable staff.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Staff understood how to protect people from abuse and concerns were acted on to protect people from the risk of abuse.

People told us there were enough staff to meet their needs safely; however, due to service changes a number of staff had left the organisation. Whilst the staffing levels were improving this needed to be sustained over time to ensure people's needs were met consistently.

Staff were recruited safely to protect people from the risk of unsuitable staff.

People's medicines were not always safely managed.

Guidance was available and followed by staff to ensure risks to people's health and well-being were managed safely. This included risks associated with; moving and handling, continence, nutrition, falls, and pressure ulcers, environmental and financial risks.

Is the service effective?

Good

The service was effective

A procedure was in use to assess people's mental capacity and identify when decisions would need to be made in their best interests. A training programme was being introduced to ensure all care staff understood the principles of the Mental Capacity Act (2005).

People were supported by staff who received an induction, on-going training and support and supervision in their role. People told us they received a good quality of care and support from the care staff.

People's nutrition and hydration needs were met by staff who knew about people's preferences and needs.

People received healthcare support from trained staff and other

healthcare professionals as required. People were supported to achieve positive outcomes in their health through the care provided.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff. People spoke positively about the care they received and the relationships they had established with care staff.

People's care plans included the choices and decisions they had made about their care. This guided staff on how to deliver appropriate care.

People told us their privacy and dignity were respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's complaints were not always investigated and responded to in a timely manner in line with the provider's procedures. People did not always feel their concerns and complaints were responded to in a helpful manner and some people did not know how to complain.

People's care and treatment plans were person centred and reflected their individual preferences and needs. People and their relatives or representatives were involved in the review of their care plans.

Is the service well-led?

Requires Improvement

The service was not always well-led

People's feedback about the management of the service was not consistently good. The registered manger was not able to fulfil all of their responsibilities due to the changes in the service structure and staffing. This had led to shortfalls in completion of processes such as complaints and incident investigations. This meant people could be at risk from inappropriate or a reoccurrence of unsafe care.

The provider had not always notified CQC of incidents which they are required to report to enable CQC to monitor the safety of the service people receive.

The provider operated a quality monitoring system and an action plan was in place to address and support the improvements required. However, the provider required more time to ensure some improvements were implemented and sustained in practice.

Peoples' feedback was sought by the provider however it was not evident this had been used to make improvements to the service at the time of our inspection. The provider required more time to analyse and address the feedback received. Arrangements in place to seek people's feedback about the service face to face had not been consistently carried out. The registered manager was taking action to address this.

Allied Healthcare Liphook

Detailed findings

Background to this inspection

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

This inspection took place on 26, 28 October and 1 November 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff and people we needed to speak to would be available. The inspection was completed by two adult social care inspectors and an expert 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.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. Prior to the inspection we reviewed information included on the 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.

During the inspection we visited four people who received a service from the provider in their homes. In addition we spoke with 12 people by telephone and the relatives of six people. We spoke with nine care staff, two care coordinators, two field care supervisors, the clinical lead nurse, a trainer, the care delivery director and the registered manager. Following the inspection we spoke with a social worker.

We reviewed records which included ten people's care plans and daily records, seven people's Medicine Administration records (MAR) six staff recruitment and supervision records and records relating to the management of the service.

The service was last inspected in July 2014 when it was rated as 'requires improvement'.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the provider's staff and their safety was supported by the service. For example; a person said "It does of course (support my safety). They can check to see you're all right." and another person said "I would say it does (keep me safe) to a fair degree." Staff completed safeguarding training on induction and then at three yearly intervals. The provider had a safeguarding policy in place and information about safeguarding was included in the care worker handbook. These documents guided staff on their responsibilities to report any concerns about abuse and who to. The provider had a 'whistleblowing team' independent of the company and staff were given information on who to contact in the event they wished to raise concerns outside of the branch or organisation. Whistleblowing is when staff report concerns in confidence and their disclosure is protected in law. Staff had the knowledge to identify and report safeguarding concerns, and acted on these to keep people safe. Where safeguarding concerns were identified, senior staff conducted investigations and took action to protect people from harm.

In May 2016 the provider made changes to their regional structure and the service previously managed from a separate location in Guildford merged with the Liphook branch. Following this change a number of staff who had worked at the Guildford branch left the organisation. This included key administrative personnel located in Guildford who planned people's care calls. At the time of our inspection the provider had not been able to directly employ enough suitably skilled staff to deliver care and treatment to the people they were contracted to support. For example, they were unable to deliver a clinical care package for a person using their own staff and had employed agency nursing staff to meet the shortfall whilst they recruited and trained their own staff. Due to a number of care staff vacancies the field care supervisors (FCS) and care coordinators were also providing personal care for people. These staff would usually be office based organising care calls or providing management support to staff in the field. The registered manager told us these arrangements had meant "The FCS and care co coordinators are tired and mistakes are coming into play for example rota checks are not done".

The provider had mitigated the risks to people from the staff shortage as far as they were able. For example, they had handed back care packages they were unable to fulfil, employed agency nursing staff and used their administrative and supervisory staff to cover calls where required. It was clear from speaking to office based staff that they were stretched to full capacity one FCS said "We have struggled but we do get there." Whilst it was evident the provider's staff were doing all they could to ensure people received the care and treatment they needed the lack of staff available had impacted on the consistency and reliability of care people received. Two people told us calls had been cancelled by the provider at short notice due to a lack of staff. A person's relative said "I never know what time they are coming; my weekly rota doesn't arrive until Wednesday". Other people told us staff were often late and they were not always informed beforehand who would be coming. It is important for people to know who will be delivering their care to protect their personal security.

People were not always notified in good time of the staff covering their calls because the office staff could not always get the information out as they were covering care calls. Staff told us they did not always receive their rota on time and this increased the risk of missed calls. For example; a staff member said "We get the

rota on a Friday rather than a Thursday. I don't get the email until I get home at 7pm then I can't query as rota starts on that day Friday. If you have the same people that's OK but there is a risk you will have a missed call when extra things are put on you don't know". People we spoke with confirmed that their care needs were being met and that they had not experienced any harm as a result of these arrangements. People confirmed they were usually informed by staff if they were running late and consulted if a call could not be made to ensure they were safe. At the time of our inspection recruitment for care staff was underway and some new staff were on their induction. Whilst we saw the provider was actively addressing staffing requirements they required more time to ensure consistent permanent staffing was in place to ensure that people's needs would be met consistently in a reliable and timely manner.

A system was in place to alert the care coordinators to any missed calls. Staff logged in to the system by telephone at the start and end of each call. If a scheduled call was missed the system would flag this up and the care coordinator would ensure the call was covered. However, some people chose not to allow staff to use their phones to log in and out of calls. This meant there was a risk the care coordinator would not be alerted to a missed call unless the person contacted the office. The provider was introducing a system whereby carers would not require the use of a phone to log in and out of calls to mitigate this risk to people.

The management of people's medicines was not always safe. Staff completed training in the safe administration of medicines prior to supporting people with their medicines. Annual competency checks were completed to check staff remained competent. However, records did not always accurately show whether people had taken their medicines despite staff receiving medication training and being subject to competency checks. The Medicine Administration Records (MAR) is used to record when people take their medicines. Providers of health and social care are required to keep this record when they administer people's medicines. Accurate recording of people's medicines is important to ensure people are protected against the risks of overdose or missed medicines. We found some recording errors in people's MAR's.

A person was prescribed a medicine which is used to prevent the formulation of blood clots which can be a serious risk to people's health. We saw that this person's MAR was not fully completed to evidence they had taken this medicine as prescribed. We were told by a FCS this was because the administration was shared with the person's relative and they did not always sign the chart. The risk assessment stated the relative would sign the chart. However, the person's care plan stated the provider had responsibility for managing the person medicines. We found the arrangements in place to protect the person from the risks associated with the irregular administration of this medicine had not been fully assessed. A safe system was not in place to ensure the person's medicine administration was recorded accurately.

During a home visit we saw that a person had a topical medicine applied during a visit earlier in the day. Topical medicines are creams and ointments applied to the skin. This was recorded in the daily notes but not on the MAR chart. We did not see a 'body map' with the MAR sheet. This would indicate the area for application of the cream to ensure it was used effectively. We found other gaps in recording of people's prescribed medicines on the MAR's of three other people. MAR charts were audited by the FCS on a six monthly basis with 20% being audited each month. We saw examples where errors had been identified and actions taken to address these. However, this system meant errors could remain undetected for some months. People were at risk because safe practice in the recording of people's medicines was not consistently followed by staff or effectively monitored by the provider.

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

People's care plans contained assessments of their risks and support needs in relation to their health and

well-being. Assessments included moving and handling, continence, nutrition, falls, pressure ulcers, environmental and financial risks. Staff told us people's risk assessments gave them sufficient guidance on how to protect people from their individual risks. Staff told us the field care supervisors (FCS) would notify them if people's needs changed. A staff member said "Risks
would be put into the care plan and we read them regularly and they are updated. The FCS gives a call or text to inform us. If I get a new client I come into the office and have a chat and see what's required." Risk assessments detailed who may be harmed from the risk and the controls and action in place to minimise the risk. For example, plans were in place to support people when they had a pressure ulcer. This included ensuring the district nurses were informed about changes and needs relating to the person's wound.

Records showed that people had been cared for safely and supported to achieve improvements and healing when they had a pressure ulcer. A staff member told us about a person whose mobility had changed and they were at increased risk of falls. They had reported their concerns and plans were put in place to promote the person's safety such as changes to their personal care routine and a referral to the fall's clinic and GP. The staff member said "She is like a different person now." A healthcare professional had written to compliment the staff on their care of a person who had healed wounds. Staff understood people's individual risks and took appropriate action to keep them safe.

Staff were provided with guidance on 'Early Warning Screening' (EWS) this encouraged staff to make routine observations at every visit. It asked 'Is the customer any different? For example; changes in the person's skin, breathing, behaviour or movement or bladder and bowel habits. Staff were then directed to report any changes observed to the office. We saw daily records referred to 'No EWS'. This meant staff used the guidance to check people against signs of deterioration in their health and safety. Staff were confident their concerns would be acted on and we were given examples of when this had occurred.

Procedures were in place to check that people were protected from the employment of unsuitable staff. These included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Identify checks and character references were obtained and candidates completed an application form with a full employment history and attended an interview to assess their suitability for the role.

Good

Is the service effective?

Our findings

At our last inspection of this service on 28 and 29 July 2014 we found one breach of legal requirements in relation to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to Care and treatment. Following the inspection the provider wrote and told us they planned to meet the requirements of this regulation by 1 May 2015. At this inspection we found the requirements of this regulation had been met.

The provider had introduced a 'Best Interest Decision Making Tool' this provided a process in line with the Mental Capacity Act (MCA) to enable staff to assess and establish if people were able to make decisions about their care and treatment. Records showed this tool had been used to assess people's mental capacity and identify when a best interest decision would be required. Staff carrying out assessments had completed training in the MCA. Not all care staff had completed this training. We spoke with one of the provider's trainers who told us this training was being included as mandatory for all staff from the week following our inspection and we saw the training pack that evidenced this. A procedure was in use to assess people's needs in line with the MCA and ensure their legal rights were upheld.

People spoke positively about the quality of support they received from the provider's staff. Their comments included "They are fantastic; they know what they are doing they just get on with it" and "I'm very happy with the care I receive, they are very obliging".

People told us that carers were well prepared for their roles. A person told us "They're doing their job nicely." Another person told us that "Staff do seem to know" what they should be doing. New staff completed an induction based on the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet to enable them to provide people with effective care. New staff attended a three day induction programme and completed a blend of practical, classroom based and e-learning training prior to supporting people with their care. New staff also shadowed more experienced staff, called 'care coaches' to learn about people's needs and to be assessed as competent in their role. A staff member told us "They (care coaches) helped me and showed me and then they observed me and signed me off with the people I then went on to support." A person said "New carers always shadow a carer before coming on their own and are introduced when they do shadowing"

A system was in place for staff supervision and appraisal. This included spot checks of staff carried out by the FCS, individual supervision meetings and an annual appraisal. Staff confirmed they received supervision and the records we reviewed showed supervisions, spot checks and appraisals had been carried out.

An on-going training programme was in place to ensure staff remained competent and updated their skills and knowledge continuously. This included; management of medication, moving and handling, food hygiene, safeguarding adults and health and safety. Where more specific training was required this was made available by the provider. For example, when people had specific health needs staff were trained by a healthcare professional and assessed for their competency in providing this specific health related care. The provider's clinical lead nurse assessed people's healthcare needs and identified the staff training required to meet them. They told us "I do the care plan and risk assessments and teach staff the principles of these. I

supervise staff and check their competencies yearly and I review the person's care every eight weeks". Staff and records confirmed they had completed the appropriate clinical training to meet people's needs. This meant people were supported by appropriately trained staff to meet their healthcare needs.

People's healthcare needs were detailed in their care plans. Staff used an Early Warning Screening (EWS) tool to enable them to assess if a person's health was deteriorating. We saw an example of how staff had used this to assess a person who required urgent medical treatment. Following an admission to hospital the person's care plans were updated to reflect their changed healthcare needs. When people developed a health condition a clinical assessment tool was completed to identify the condition and refer the person to the clinical services team for further assessment. Staff followed the recommendations of healthcare professionals such as district nurses and Speech and language Therapists (SALT) to ensure people received the care they required. For example; thickened fluids to enable people to swallow safely, managing equipment safely to support breathing obstructions and supporting a person with their enteral feeding device. Enteral feeding refers to the delivery of a prepared feed via a tube directly into the person's stomach.

People who were supported with food preparation or eating had care plans in place which described the support they required and their preferences. For example there was a suggested preferred sandwich on the care plan of a person who may not always make a choice. A person with specific dietary needs had detailed visit summaries that described these and how the person preferred to be supported with their meal planning and preparation. Staff told us they offered people choices and spoke about people's preferences such as 'thick sliced' bread. A care staff member said "If I make a cup of tea I find out how much milk people like, it's important to know what each person wants." Meeting people's dietary needs and preferences helped to ensure people maintained adequate nutrition.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and compassionate. People's comments included "Carers are kind and considerate, that's important to me" and "Absolutely magnificent care, friendly and caring".

A care coordinator told us how they tried to match care staff to suit people's personality and preferences. They said this can sometimes be 'trial and error' but "In the end we give people what they want". For example, they told us how a person was refusing care from younger staff but had responded well to an older care staff member who now provided their care and had built a good relationship with them. Whilst the provider tried to meet people's preferences about which staff supported them this could not always be met due to staff availability and some people commented on this.

People and their relatives told us that care staff respected people's privacy and dignity when supporting them with personal care. Staff we spoke with described how they promoted people's dignity and how they encouraged people to retain their independence by encouraging people to self-care wherever possible. A care staff member said "I put myself in their (person's) shoes; I do what I would like a carer to do for me". People confirmed they received care in the way they preferred.

Relationships between people and care staff were monitored through spot checks by FCS in the person's home. An FCS said "We look at how they (staff) communicate with the person, how they behave and we get them to tell us a bit about the client". This was to ensure staff demonstrated a caring and person centred approach.

Staff spoke in a caring way about the people they supported. Staff appreciated they supported people in their own homes and were mindful of the need to respect people's privacy and wishes. For example, a staff member told us about how a person preferred the two care staff that supported them to arrive together and they arranged this. Another staff member said "I greet everyone and treat them as I would like to be treated myself. You may be the only person they will see that day and you have to respect it is their home". A person's relative described the staff as "Respectful". A person told us that carers always asked, before they left, "'Is there anything else you would like me to do?" During a home visit, we observed that the carer did ask this. The person responded by asking for another cup of tea which the carer brought to them. People were supported by caring staff.

Peoples care plans were written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about their background and what was important to them in the care they received. Detailed visit summaries provided staff with information and guidance on how people preferred to be supported and their decisions. A staff member told us how these care plans helped them to provide appropriate care especially when people were not always able to express their choices or needs.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us the care they received was 'good'. However, most of the people we spoke with raised concerns about their care arrangements. For example; some people told us they did not always receive advance notice of which staff would be providing care and their call times and this made it difficult to plan their day. Other people told us that staff were frequently late and did not always attend at the times they preferred their visits. People and their relatives did not always feel the provider has responded appropriately to the complaints and concerns they had raised with the provider. For example, two people said they felt office staff were "short with them" and "resented" them raising concerns. Some people felt concerned for care staff who had told them they were "stressed" and "overworked" and did not want to complain about late calls for fear this may cause additional stress for these care staff. One person said "I don't want to get anyone in trouble it's not their fault".

Two people told us although they had raised complaints one had not been responded to and another said although improvements had been made this had not been sustained. People we spoke with were unable to tell us about the provider's formal procedure for making a complaint. In a quality assurance survey (completed in June 2016) 20% of people answered 'don't know' when asked if they were aware how to make a complaint. The Care Delivery Director told us they would ensure that the provider's information about how to make a complaint would be re-issued to people in response to this feedback. Both the care delivery director and the registered manager told us that dealing with complaints had fallen behind timescales due to the pressures of other work.

We reviewed the records of complaints and saw that seven complaints had not been investigated or responded to in good time. The provider had a set timescale of responding to complaints within 15 days with a final response within 28 days. In these examples the timescales had not been met and the complaints remained unresolved. These complaints included late calls, missed calls changes to the time of call and the rota of a person's calls not being received prior to the start of the rota. Although a system was in place for the provider's customer service team to monitor and chase response times this had not always been effective in ensuring the timescales were met. We did not find that a complaint of a very serious nature had not been addressed. However, there was a risk to people from an on-going failure of the service when complaints were not investigated and addressed within a timely manner.

The failure to investigate and act on all complaints received and to operate an effective system for handling and responding to complaints was a breach of regulation 16 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The provider supported people with personal care and with some healthcare needs. People's care needs had been fully assessed and documented before they started receiving care. These assessments were undertaken in people's homes or in hospital to identify their support needs and care plans were then developed outlining how those needs were to be met. Where people required healthcare support their care was assessed and overseen by the clinical lead nurse.

At our last inspection we noted that care plans were mainly written in a 'task orientated style' and did not sufficiently detail people's personal preferences. The provider had since introduced a new care plan format. The care plans we saw were personalised and current and the daily notes of care we read were relevant and detailed. Care plans were centred on the person's individual needs and preferences and included detailed visit summaries which described the care to be provided at each call including people's preferences. There was a written plan to guide staff on the personalised care people required.

We saw examples of the involvement of people's relatives and representatives in care plans and a relative told us about a recent review and update of their relatives care plan which they participated in. A relative said "The carers always put any incidents in the notes; It's really useful for me". Care plans included information about who else was providing support to the person and the persons consent to share information with named people.

A monthly virtual care round was facilitated by the clinical lead nurse. This meant that people receiving healthcare support were regularly reviewed by the clinical team to identify any concerns, progress or changes. We spoke to the clinical lead about this and reviewed the records of these meetings. We saw that where actions were identified these were followed up and completed.

People's individual needs were routinely reviewed every 12 months or when their needs changed to provide the most current information for care workers to follow. Staff told us they read through the care plans and the daily log books to check people's needs. When staff were asked to support a person they had not visited before they were given information by the care coordinators and referred to the person's care plans. Staff we spoke with told us they generally had sufficient information prior to visiting people about their care needs.

Requires Improvement

Is the service well-led?

Our findings

People's feedback about the management of the service was not consistently good. People told us they did not always feel they were listened to or that they always received a helpful response when they contacted the office. Some people felt that 'management' were "uncaring" and at times unresponsive. Whilst people were consistently positive about the care they received they did not always feel the service was well managed. A person told us the service was "slightly not well-managed" and that contacting the service could be difficult with the phone "ringing and ringing – I left so many messages". A person's relative told us the service "has been well-led" but "maybe needed a more communicative manager" and "better co-ordination sometimes".

The registered manager told us that changes to the service such as the sudden departure of key staff and the addition of the Guildford location to the branch had created management challenges. For example; existing care coordination staff were coordinating care for people in an area they didn't know, with staff they didn't know and with a reduced availability of care staff. This had caused some disruption to the quality of service people experienced and had impacted on existing staff and service developments due to reduced resources and increased workloads. The registered manager had been required to take on additional responsibilities due to a reduction in administrative staff at the branch office. This had impacted on their ability to sustain some of their responsibilities and achieve development goals. For example, the registered manager said they had fallen behind in dealing with complaints and incidents and areas identified for action and improvements in the service action plan.

Records showed incidents such as some missed calls had been reported to the provider. These incidents were logged and monitored by the provider's customer services team to ensure an investigation was conducted into the reason for the missed call and action taken to prevent a reoccurrence. We noted that several incidents had been reported and had not been investigated. The provider set a timescale for incidents to be investigated and resolved and these had not been met. The registered manager told us they had fallen behind with these investigations due to the pressure of other work. We were therefore unable to assess the impact of some of these missed calls on people. However, we did see two examples of missed calls that had resulted in missed medicines for people that had not been fully investigated to identify the reason and impact, mitigate any harm and to prevent a reoccurrence. This meant people could be at risk where incidents were not investigated and managed promptly.

Risks relating to the health, safety and welfare of people were not always assessed, monitored and mitigated in a timely manner. This was a breach of regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The provider had not always made CQC aware of allegations of abuse. Providers are required to notify CQC without delay of any abuse or allegation of abuse. This is to enable CQC to monitor the safety of the service people receive. Although the provider monitored the management of safeguarding matters they had failed to ensure all the relevant notifications were sent to CQC. This was a breach of regulation 18 of the CQC (registration) Regulations 2009.

The registered manager and care delivery director were aware of the key challenges to the service and it was apparent they were working towards achieving an improved service for people. For example; at the time of our inspection the provider had recruited to a new post of care delivery manager aimed at providing additional support to care staff working in the Guildford area. The registered manager had also held meetings with staff and planned to continue these to build relationships and develop a consistent approach and positive culture across the whole service following the service changes. The provider was taking action to recruit new care staff and at the time of our inspection induction training was taking place for recently recruited staff. The provider was supporting the retention of existing staff by offering incentives such as the 'perk box' offering staff money off goods and services. The registered manager told us they were "Working hard with staff from the Guildford area to develop templates of where they go and what they do and identify any gaps" to improve the coordination of people's care where required.

A service action plan was in place based on targets identified by the provider. This included activities for improvements in areas such as quality, training, staff retention and recruitment. Progress was regularly monitored by the care deliver director. We reviewed the last update dated 13 October 2016. Records showed some improvements had been achieved such as drop in sessions for staff with managers to address concerns. Actions were monitored for progress within timescales. We saw the action plan had identified the need for complaints and incidents to be investigated and resolved within the provider's required timescales, but these had not been completed. Completion of the action plan was necessary for the required service improvements to be made. Given the feedback we received from people and the impact of the service changes on people, staffing and management more time is required for the service to consistently implement and sustain these improvements in their practice.

People were asked for their views on the service by the provider and we saw the results of a customer satisfaction survey carried out in June 2016. People were asked about their views in relation to; staff skills, punctuality, and consistency of staff and the impact of the service on their quality of life. Whilst the majority of people felt the service was 'good' the feedback also showed that some people were not satisfied with the consistency and punctuality of care staff and did not find that branch staff were always helpful. At the time of our inspection an action plan had not yet been produced from this feedback to identify actions for improvement.

A system was also in place to check the quality of service people received through annual individual face to face customer quality reviews. This enabled people and/or their representatives to give feedback about the service in person to a reviewer from the service. However, the registered manager told us these had not been consistently carried out. In four of the care files we reviewed there was no evidence that a quality review had been conducted and in one person's file the last quality review was carried out in 2014. People we spoke with were unable to recall being asked their views or being asked for their feedback on the service. The registered manager told us they planned to request that FCS carried out these reviews when they visited people to review their care plan to ensure people's views were gathered to drive improvements to the service. The provider required more time to implement and embed this consistently into their practice.

The registered manager regularly met with all staff to provide feedback and information. Team meetings were held every three months over two or three days to enable staff to attend. The registered manager said "we don't always capture everyone" but went onto say slides and a presentation were put into the minutes and these were sent out to all staff to ensure they were kept informed. A staff member told us the meetings were useful and said "(The registered manager) has tried to get everyone moving in the same direction, care workers and FCS. He uses meetings to try and explain the difficulties and increase understanding between the sections. He brought home how difficult it is to do your job is others don't do theirs". Weekly branch meetings were held and a branch staff member said "We discuss issues with carers and clients like sickness

that week or if (the registered manager) wants to bring anything to our attention". Arrangements were in place to enable the Guildford based staff to meet with the FCS for that area weekly at a convenient and accessible location in Guildford. Staff located nearer to Liphook were able to call into the office if they required information or support and we observed this during our inspection.

The provider did not have a publicised set of their own values to guide staff behaviours and attitudes. Staff completed an induction programme that covered the principles of providing safe person centred care and the values that underpin this, their duty of care and the principles of equality and inclusion. Staff told us they understood their responsibilities which were reinforced and monitored through competency checks. A staff member said "It's the whole aspect of caring for people and making sure you are doing it in a proper and correct manner they (FCS) do come out and check. I do my best and treat people as you would want to be treated."

The provider kept staff informed of news and developments within the company via a weekly news and updates bulletin. This included updates on policies, training and news from other branches.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify the CQC without delay of incidents that must be notified to the commission.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always safely managed. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to investigate and act on all complaints received and to operate an effective system for handling and responding to complaints. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks relating to the health, safety and welfare of people were not always assessed, monitored and mitigated in a timely manner. Regulation 17(2) (b)