Harmony Home Aid Services Limited

Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park

Inspection report

Unit A2 Broomsleigh Business Park
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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 3 and 11 October 2017 and was announced. Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park is a domiciliary care service. The service is registered to provide personal care for people living in their own homes. At the time of the inspection, 135 people were using the service.

The last time we inspected this service on 15 and 20 December 2016 the service was not meeting all the regulations. Three breaches of regulations were found. We found that the service was in breach of regulations in relation to safe care and treatment and good governance. We issued warning notices for each breach. The registered provider was also in breach of the regulation related to notifications. We issued a requirement notice for that breach of regulation. The overall rating for this service was 'Inadequate' and the service was placed in 'special measures'. You can read previous inspection reports for the service, by selecting the 'all reports' link for Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park on our website at www.cqc.org.uk.

At this inspection, we followed up on the breaches of regulations to see if the registered provider had made sufficient improvements. We found that the registered provider had taken some action to meet the regulations. The registered provider now met the regulation relating to notifications. They had also taken action to manage risk management plans, the management of missed and late visits, the management of medicines, the quality assurance process and improvements in the management of the service. However, further improvements were required.

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.

People had assessments which identified risks associated with their health and well-being. However we found that the control measures in place to manage risks were not always followed to keep people safe.

People's medicines were not always managed safely. People's medicine administration record (MARs) charts were not always accurate or up to date. People were at risk of receiving medicines that were not administered as prescribed. The registered manager had implemented a new medicine audit tool. However, this was not effective as it had not identified the concerns we found.

The registered manager had systems in place to monitor, review and improve the quality of people's care records and risk assessments. However this system was not effective because information contained in people's care records was not always accurate.

Missed and late visits were recorded and monitored. However, there was evidence that staff were not always

reporting missed visits to the local authority.

The registered provider had a recruitment system in place. Staff followed the recruitment process to ensure staff had pre-employment checks carried out to assess their suitability to work with people. However, we found that on two occasions the provider had not followed up information contained in pre-employment checks to ensure that staff were safe to work with people. The provider sent us further information following the inspection to evidence how they had addressed this.

Staff had regular training, supervision and an annual appraisal. Newly employed staff had an induction which helped them familiarise themselves with the service and the expectations of their role before they started working with people.

There were enough staff to meet people's care needs. The rota showed sufficient staff were deployed to meet people's care and support needs safely.

The registered provider had safeguarding processes in place that staff followed to help keep people safe.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had training in the MCA and understood how to raise a concern if they thought a person's ability to make decisions for themselves had changed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to make decisions about their care and support needs and consented to their care and support where possible. Relatives were involved when people were unable to consent to care from the service where this was appropriate.

People had an assessment of their needs. Information from care needs assessments was used to develop a plan of care. When people's health needs changed staff ensured they had appropriate support from health care services.

People commented that staff treated them with thoughtfulness and compassion. Staff spoke about people with empathy demonstrating that they were kind and caring.

The registered provider had a complaints policy in place at the service. People had the support to make a complaint about the service if they needed to. People told us they would speak with the care worker and office based staff if they had any concerns about their care.

Staff routinely obtained people's views of the service. There were systems in place which meant people were able to provide feedback to the registered provider about the quality of care they received.

Staff prepared meals for people. Staff completed shopping tasks so people had enough food and drink. Meals met people's needs and preferences. Staff supported people to be as independent as possible and supported people in their local communities as they chose.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of

Special Measures.

We found two continued breaches of regulation in relation to safe care and treatment and good governance, however, improvements in these areas had been made since the last inspection. 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. Risks to people's health and well-being were identified. However, risk management plans did not always mitigate the risks in relation to people's safety.

People did not receive their medicines safely because systems used for the management of medicines were not effective.

People received their visits as planned. There was a system in place to monitor missed and late calls, however the outcome following a missed visit was not always recorded.

Recruitment processes were in place. Criminal record checks were completed before staff worked with people. However, staff did not always have a risk assessment recorded on their staff records where this was appropriate.

People were protected from abuse because staff understood what action they should take if they had concerns about a person' safety.

Enough staff were deployed to meet people's needs safely.

Is the service effective?

Good

The service was effective. Staff had regular training, induction, supervision, spot checks and an appraisal whilst employed at the service.

Health care support was made available to people when their health needs changed.

Meals provided met people's needs and preferences.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed by staff.

Is the service caring?

Good

The service was caring. Staff understood people needs and knew them well.

Staff respected people's views and choices. Staff were caring, kind and compassionate towards people and their relatives.

Is the service responsive?

Good

The service was responsive. An assessment of people's care and support needs took place before they used the service.

People made choices on how they wanted to have their care and support provided.

The registered provider had a complaints system in place. People understood how to make a complaint if they were unhappy with their care.

Is the service well-led?

Requires Improvement

The service was not always well led. The registered provider's quality systems were not always effective.

Staff understood their roles and responsibilities but did not always feel supported by the registered manager.

The registered manager understood their responsibilities in relation to their registration with the CQC

Harmony Home Aid Services Limited - Unit A2 Broomsleigh Business Park

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 3 and 11 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be in. The inspection was carried out by 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. Their area of expertise is in services for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us with the planning of the inspection.

We spoke with 21 people who used the service and four relatives. We also spoke with the registered manager during the inspection.

We looked at 10 care records, seven medicine administration records (MARs) for people, 10 staff records and other documents relating to the management of the service.

After the inspection, we spoke with the head of training at the service. We also received feedback from three care workers and four health and social care professionals from the local authority and Clinical Commission

Group (CCG).

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 15 and 20 December 2016 we found that the registered provider had breached the regulations we inspected. The registered provider did not safely manage, mitigate and reduce risks to people's health and well-being. People's medicines were not always managed safely because medicine administration records (MARs) were not completed correctly or reviewed for their accuracy. Systems for monitoring missed and late visits were not effective because people told us they experienced missed and late visits. These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the provider had made some improvements however, some records still contained inconsistencies that meant people could have been at risk of receiving unsafe or inappropriate care. Care records did not always contain accurate information to enable staff to mitigate risks. For example, one person's care plan indicated they did not use a hoist for mobilising. However, their moving and handling risk assessment included directions for care workers about using a hoist to help the person get in and out of bed. In another example a person's care plan noted that they had no history of wandering at night. However, staff had recorded that the person had been found by their neighbour wandering and disorientated.

Risk assessments identified risks associated with people's health and well-being, however again these were not always accurately or fully completed to ensure that staff had appropriate guidance to keep people safe. For example, staff had identified five people as being at risk of developing a pressure ulcer, but had not documented pressure areas on body maps so staff knew what areas required protection. In another example, two people's care records noted that they were not at risk of pressure ulcers, however this was then contradicted as one stated the person could be at risk of pressure ulcers due to continual sitting and also noted existing ulcers on their legs and the other stated that the person suffered with pressure ulcers. This meant that the provider had failed to ensure that records accurately recorded identified risks to ensure that people received safe and appropriate care and support.

We spoke with the registered manager about the errors we found in the risk management plans. He told us that the office based staff had updated people's risk assessments but acknowledged that there were errors in the risk assessments.

These issues were a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the provider had made some improvements in relation to the safe management of medicines, however people's medicines were still not managed safely. The registered provider had reviewed their medicine policy since the last inspection. People had their medicines dispensed by their local pharmacist. Medicines were delivered in a dossette box, blister pack or in the original medicine packaging. Most people told us that they had their medicines as required. One person said, "I get my medicine on time." Another person told us, "My [family member] sorts out my tablets." However, one relative said, "Some care

workers have forgotten the tablets. The afternoon care workers were finding tablets in (my family member's) bed. She did speak to the morning care worker who said, it's only a tablet." We informed the registered manager about this concern. They told us that any concerns regarding medicines were discussed with the member of staff by their line manager. We looked at the medicine training for staff. Staff attended training in the safe management of medicines. This enabled staff to understand how to support people with the administration of their medicines in a way that was safe.

Staff told us that blister packs were ordered from the local pharmacy. The pharmacy provided details of each medicine prescribed. Each person who required support with their medicine had a medicine administration record (MAR). The registered manager and office based staff had requested that staff return completed MARs to the office. This was to enable office based staff to review these for accuracy. We asked the registered manager for copies of all MARs available in the office on the day of inspection. We found inaccuracies in these. For example, we found the names of the medicines were not always attached to or written on each MAR when these were returned to the office. We also found on one occasion the name of a medicine that was prescribed was spelt incorrectly. We identified seven occasions where staff had not used the correct code to demonstrate a medicine was not administered. We also found that staff did not always sign the MARs when a medicine was administered. This meant that MARs did not accurately reflect whether people had received their medicines as prescribed.

The training manager had implemented an audit for missed doses of medicines which included sampling MARs from each of the London boroughs the provider worked in. We looked at the most recent audit and found that the information was unclear and included people who did not receive support with medicines. In addition the audit identified the number of individual pills missed according to MAR charts over the space of a month but did not identify how many doses this represented or why they were missed. There was also no documented follow-up. This represented a significant risk because some people were noted to have high numbers of missed pills. In one instance a person was noted as having missed 96 pills in September 2017, which represented 32% of their prescribed medicine. We asked the registered manager about this incident, they told us they had not alerted the local authority of this safeguarding concern.

These issues were a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had implemented a new system to monitor and review missed and late calls. We spoke to people about whether their care workers attended all their visits and arrived on time. One person told us, "They arrive on time and stay for the right length of time. I don't think they have ever missed a call. The staff ring me if they are going to be late." Another person told us, "Yes they are not bad, within 5 or 10 minutes. I think that is very good as they come by bus." A third person said, "Yes, they are usually on time. They have never let me down."

The registered provider recorded each missed and late visit that occurred at the service. The registered manager told us that all missed visits were raised with the local authority that had commissioned the care. We looked at the records of missed visits and the communications with the local authority informing them of the missed visit, however some of these were not accurate and did not match.

Staff understood how to protect people from abuse. The registered provider had a safeguarding policy in place. The safeguarding process provided staff with guidance on how to protect people from the risk of harm. Staff knew the signs of abuse and the actions to take if they suspected abuse was taking place. Staff completed training in safeguarding and understood the different types of abuse and what actions they would take to inform the local authority of an allegation of abuse. Staff told us they would raise a concern of

abuse with their manager. There was a system in place for office based staff to inform the local authority of allegations of abuse.

The registered provider had a whistleblowing policy in place at the service. Although care workers demonstrated a good knowledge of safeguarding, it was not always evident that staff understood whistleblowing. For example, four care workers said they had not heard of whistleblowing and seven care workers said they would be reluctant to raise concerns because they said this could not be done anonymously. Another care worker said they had previously had concerns about the conduct of a colleague but did not feel confident enough to report it. We recommend that the provider seeks advice from a reputable source about how to ensure that staff understand whistleblowing and their rights and responsibilities in relation to this.

There were enough staff deployed to care for people safely. Records clearly showed where people required two members of staff to support them. People shared their views about whether there were sufficient staff available to support them. One person said, "I think they do, yes. I never have a problem with them." Another person said, "Yes, they never seem short staffed."

The staff rota showed the number of staff people required and this was implemented by the office based staff who were responsible for arranging the staff rota. People we spoke with were happy with the regular care staff that supported them. One person told us, "They [staff] have settled down to the same one now." Another person said, "Yes, I have the same small team of staff." This showed people had staff that provided care and support that was appropriate and consistent.

The registered provider had a staff recruitment process in place. Staff followed this process to ensure only suitable people were employed to work at the service. Pre-employment checks were carried out on new employees to assess their suitability to work with people. Staff records included an application form, job references, interview records and criminal record checks. This information was used to assess the suitability of staff. We found that two staff had recorded information under the Rehabilitation of Offenders Act 1974. We found on one occasion this information was not completed correctly as required on the application form. We spoke to the registered manager about this and they agreed to send us further information. We received two risk assessments competed for each of the applicants which assessed their suitability.

Good

Is the service effective?

Our findings

At the last inspection on 15 and 20 December 2017 we found that the registered provider had breached the regulations we inspected. The registered provider did not enable staff to have an appraisal in which the line manager made comments and contributed to staff performance in the previous year. This issue was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had made improvements.

The registered provider supported staff in their roles. Staff had an appraisal of their performance each year. Staff were able to review progress in their role and able to discuss their training and development needs. The line manager made comments about staff performance and any development needs on staff appraisal records. For example, one line manager had documented that a member of staff was to be referred for additional training to support them in their job.

Staff had regular supervision and face to face meetings with their line manager. During these meetings staff discussed any difficulties they had whilst working with people. Their line manager was able to offer advice and this was recorded on the supervision notes. Staff and their line managers had signed supervision records and added this information to staff files.

Care supervisors used a 'red amber green' (RAG) rating system to monitor staff competency in relation to the delivery of care. For example, during spot checks care supervisors rated staff knowledge of areas such as safeguarding, dementia care and personal care using the RAG rating. Where a care worker was rated green they received a note of commendation from the senior team. An amber rating indicated there were areas for additional support and training and a red rating indicated there was a need for immediate and significant improvement.

The registered provider had a system in place to support new members of staff. Newly employed staff were matched with senior and more experienced staff during their induction to the service. New members of staff 'shadowed' experienced staff. This helped them develop their skills and knowledge in supporting people receiving care. We spoke with five care workers about their induction experience. Each member of staff was positive about the overall experience, but two individuals said they felt it was "too condensed" and "rushed." However each individual had the opportunity to provide feedback and said they felt confident their views were taken into account. The induction programme for staff also enabled them to become familiar with the registered provider's policies, procedures and practices. Staff assessed as being competent following their induction were then able to work independently.

A training manager supported staff with regular training. There was a training matrix that contained the training programme for staff. We saw that staff had completed mandatory training. This included safeguarding adults, basic life support, infection control and medicines management. People we spoke with felt that staff had the skills to support them safely. One person said, "I think they have all the skill and training they need for me," Another person said, "I think they are very well trained and professional care workers." Staff were positive about the training they received. All of the care workers we spoke with were

positive about training opportunities and the support of the training manager. One individual said, "[The training manager] is the reason I love working here so much. They've helped me to make sure I give the best care I can." Care workers said the safeguarding and mental capacity training they had helped them to provide care that met people's needs. This included where a person had reduced mental capacity and where care workers needed to make decisions in line with the Mental Capacity Act (2005). The provider supported care workers with additional formal training and professional development, including the completion of National Vocational Qualifications (NVQs) in health and social care levels two and three.

Care workers told us they were able to secure additional and specialist training when needed. For example, if a person they provided care for experienced a change in their needs, the care worker would speak with a supervisor about the additional training they needed to continue providing appropriate care. This was completed by a supervisor alongside a needs assessment, which care workers told us was a positive method to ensure extra training was appropriate.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. DoLS applications for people living in their own homes must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence that staff had contacted the local authority when people's ability to make decisions for themselves changed. When required, people had a mental capacity assessment, where best interests decisions were recorded and followed by staff. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff we spoke with understood their responsibilities to care for people appropriately in line with the MCA.

People consented to their care and support. They told us that staff asked them for their consent before providing care. One person said, "They do when they are helping me shower." A relative told us, "Yes they do ask (my family member) permission before they do anything." All of the care workers we spoke with demonstrated a knowledge of providing care to people living with dementia, including when people had reduced mental capacity. For example, each care worker explained how they developed strategies to engage with people who could not clearly communicate due to dementia. This included how to gain consent and how to ensure people could tell them they needed something or were in pain.

Staff recognised when people's health care needs changed. They supported people to access health care services when needed. For example, when a staff member had observed that a person's mental health had deteriorated they reported this change to the office based staff who contacted the person's healthcare professional. The healthcare professional was able to visit the person to review their mental health needs and offer appropriate advice and support to them. We saw records that demonstrated that staff made referrals to health and social care professionals for guidance and specialist advice. Care workers we spoke with explained their part in each person's multidisciplinary care team and demonstrated how they ensured each person received individualised care as a result. For example, one care worker met with the district nurse and allied health professionals responsible for supporting one person when they started providing care for them. This meant the care worker was able to create a care plan that met the individual's specific

needs and ensured their care plan included the input of other professionals responsible for their care. All of the care workers we spoke with knew how to contact other health professionals when needed and said supervisors were supportive when they thought a person needed additional medical support. We saw positive examples of care workers contacting other teams when a person's needs changed. For example when one person was hospitalised, their care worker contacted the adult early intervention team to help coordinate support and care.

People had meals, which met their needs and preferences. People we spoke with told us that staff supported them with meal preparation and shopping. One person said staff did not support them with meals. They added, "No but they do help me with shopping because of the heavy bags." A second person told us, "They cook my meals how I like it and they serve it to me." People and relatives gave us positive feedback about how staff supported them with purchasing shopping, providing meals they enjoyed and they had knowledge of people's individual dietary needs.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were caring. People commented positively about the staff providing their care and support. One person told us "Very much so, nothing is too much trouble." A second person said, "Yes they are lovely ladies." A relative said, "I do, yes. I think they are all excellent and [my family member] gets on very well with all of them."

People and their relatives were able to plan and make decisions about their care. Care records described people's preferences for care, also what things people enjoyed doing. For example, people were able to inform the office based staff of the time they wanted the care worker to arrive. People told us that the office staff were flexible in meeting their needs and any changes at short notice.

People were supported to be independent and do tasks for themselves where they were able to do so. People attended appointments and social activities with the support of care workers. For example records showed that two people attended a day centre weekly. Care staff accompanied them to the daycentre to support them to maintain their independence whilst taking part in activities they enjoyed.

Staff knew people's individual needs and abilities. Care assessments were completed before people started using the service. People told us that staff cared for them and understood their needs and views well. One person told us "They know me and know exactly what they are doing." Another person said, "Yes they know me very well and my likes and dislikes." People told us that staff had enough time to provide care and support to them because staff rotas were organised to allow travel time.

All of the care workers we spoke with demonstrated knowledge of providing care to people living with dementia, including when people had reduced mental capacity. For example, each care worker explained how they developed strategies to engage with people who could not clearly communicate due to dementia. This included how to gain consent and how to ensure people could tell them they needed something or were in pain.

People's care and support needs were reviewed on a regular basis. People's relatives and relevant health and social care professionals contributed and participated in the review. This process took into account those views to ensure the most relevant information was made available. This information was incorporated into the care review to ensure the most accurate information was available.

People said staff showed them kindness and compassion when supporting them. A person said "They've [care workers] been looking after me for 14 years. The care workers are kind and caring. They are top of the world. The (replacement care worker) is also good." A second person told us, "I love my (care workers). So kind and thoughtful and I've been with Harmony for over 3 years. I was very worried I would lose Harmony when I came out of Hospital. Thank goodness, I didn't." Staff we spoke with were respectful of the people they provided care to. We asked members of staff about how they supported people to make decisions. A member of staff told us, "People need our help and we are there to make sure they have the help they need." Staff were able to demonstrate that they cared for people in a way that showed they respected their views,

their home and relatives.

People were cared for by staff who respected people's dignity and privacy. One person said, "When I'm having a wash they cover me up so I don't get embarrassed. They don't force me to do things and they let me get on at my own pace" Another person said, "They are very gentle and lovely to me. Never expose me and keep me decent. The regulars always spend time chatting with me." Other people told us that that staff would always knock on their bedroom doors before entering and ensure all personal care tasks were carried out in privacy.

Good

Is the service responsive?

Our findings

Staff met people's individual care and support needs. A supervisor conducted an initial individual assessment before each person started using the service. This included a discussion with the person about what they would like help with. We saw care workers were proactive and identified improvements that could enhance a person's quality of life. For example one care worker noted a person needed a new wheelchair to be able to access the community, which was then provided.

Assessments provided staff with enough information to determine the level of support people required. People confirmed that these assessments took place. One person said, "Yes the manager came to do an assessment" and "I think they did an assessment, yes." A relative added, "Yes, they did do an assessment of (my family member's) needs before (my family member) started with them." Following an assessment of their needs staff developed a care plan which described the level of support required to meet these. One person said "Yes I have a care plan." Another person told us, "Yes she has a care plan. It is reviewed regularly."

Care plans showed that care staff consistently involved people when planning their care. For example, six monthly care reviews included a one-to-one discussion between a care supervisor and each person to identify how they felt about their care and whether there was anything else they needed help with. People completed six monthly quality monitoring questionnaires and were asked if they were involved in discussions about their care as part of this. In the questionnaires we looked at, all the comments were positive and people indicated they were always involved in discussions about their care. Office based staff carried out regular reviews of people's care with relatives where appropriate. Staff maintained a detailed record of the individual needs of people and reviewed this at least every six months. During reviews people were asked if they felt their health and wellbeing needs were being met.

Although care plans were individualised, there were some inconsistencies in this information. Each person had a 'self-care mobilisation advice' sheet but staff had not always modified these to reflect people's individual needs. For example, one person's self-care sheet gave advice about how to take a bath but their care plan stated they did not take baths. There was evidence care workers got to know people and the social and personal sections of care plans reflected this. For example, one person became agitated when around loud noises and staff managed this by ensuring they used paper towels instead of hand dryers when assisting the person to use the toilet. Another person's care plan detailed their favourite music and when staff should play this for them.

The registered provider continued to support people to make a complaint about the service. People knew if they were unhappy about the service they could complain. One person told us, "(I have) no complaints at all." Another person said, "If I had a complaint I would talk to the supervisor." During home visits a care supervisor asked each person if they understood the complaints procedure as part of their six monthly reviews. In all of the examples we looked at it was recorded people understood how to complain if needed. One person told us that they had made a complaint about the service they received. They told us that their complaint was investigated and staff provided them with a response and had taken the action they wanted.

They told us that they were happy with how their complaint was managed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 15 and 20 December 2017 we found that the registered provider had breached the regulations we inspected. Systems to monitor missed care visits, the number of people receiving a service and the quality of the service were not effective. We also found that people were at risk because their care records and risk assessments were not regularly checked to ensure they were of a good standard and reflected their current needs. These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager did not inform the Care Quality Commission of incidents that occurred at the service which by law they were meant to tell us. These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Registration Regulations) 2009.

At this inspection we found that the service had made some improvements to the service. However, there were still further improvements required.

People told us that they felt the service was managed well. They told us, "I am very happy with them. Yes I do." Another person said, "On the whole I think it is." A third person told us, "Yes I think it is an excellent service and is very well managed." People shared their views about the management of the service. They told us that when they contacted the office staff they had been helpful. One person said, "Everyone in the office were helpful, very good. I only have to ask and it is done." Another person said, "I think it's well run. I get that feeling."

However, despite these positive comments some people did not know who the registered manager of the service was. We received comments such as, "I don't know who is in charge." A relative told us, "(A member of staff) is in charge and he's asked for verbal feedback." Another person said, "[another member of staff] is in charge and she visits once a year." Although people were not always clear about who the manager of the service was they knew they could contact the office if they needed to.

We asked the registered manager for up to date records for people using the service. The records we were provided with contained details of people who no longer used the service.

Since the last inspection a new system to manage missed and late visits had been introduced. The registered manager confirmed all incidents of missed and late visits were shared with the relevant commissioning local authority. We saw records of missed visits that occurred and these were sent to the local authority. People we spoke with told us that care staff spent the correct amount of time allocated to them but said that sometimes care workers would arrive late. People told us that the care worker or office based staff would usually contact them about the lateness of their care visit. One person told us, "The (care workers) ring me if they are going to be late" another person told us, "If they are late they, (care worker), ring me." There were records in place to document and monitor missed visits, however, these did not record what action was taken to resolve any issues, if there were risks associated with a missed visit and whether the person had their care as planned. This meant that this system did not effectively monitor and manage visits to ensure that these took place and improvements made where issues were identified.

The registered manager discussed the changes they had made to improve services for people. There was a new process in place to review the quality of the care records. People's care records including, risk assessments, care plans and medicine administration record sheets (MARs) were reviewed for their accuracy and quality by staff.

The process in place to review the quality of care was not effective. We found that care records that had been audited had not been updated and we found some shortfalls in care records that had not been identified. This meant that risk management plans did not identify and manage the risks associated with people's health and wellbeing.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

All of the care workers we spoke with said they felt well supported in their role and felt the senior team cared about their wellbeing and work-life balance. Care workers said supervisors were easy to reach by phone and that if they did not receive an immediate reply there was always an on-call manager to talk to. One care worker said, "I've stayed here [with this company] for so long because of the 'family feel'. Nothing is ever too much trouble for them and I think we're watched very closely to make sure we do a good job but also so we have the support we need." Care workers described an approachable leadership team and said supervisors and managers were available whenever they needed them. One care worker said the ability of office-based staff to provide support was "variable" and said this was because of a broad difference in levels of experience within the team. Another care worker said, "The supervisors are supportive but we often have to chase them to get things we've been promised. We always have to do what's expected of us but it's disappointing others are not held to the same standard."

Care workers we spoke with welcomed the opportunity to meet colleagues at training days and said there was always time to share experiences, learning and best practice. None of the care workers said they attended meetings but that training days were mandatory, which meant they had the chance to meet with senior staff. We saw that the registered provider had organised regular team meetings, however staff fed back that this was not accessible to all care workers. Records we looked at showed that senior staff offered some support to care workers, however there was some indication that staff were not encouraged to be open transparent with inspection staff who visited the service.

Five care workers gave examples of raising concerns with the senior team about care or the conduct of colleagues. In most cases care workers said managers had listened to them and acted on their concerns. However, one care worker said, "It's difficult to know what to do when some [care workers] always try and cut corners. I've told the supervisors about this but other than spot-checks there isn't a system to stop bad practice." Another care worker said, "I don't know if telling managers about my worries is a good thing to do. I did this once when I saw another care worker not doing a good job but there was very little follow-up." One care worker said, "The standard of care workers is variable; those that struggle or don't do their job properly are not always coached to improve."

Care supervisors led a quality assurance process that included six monthly spot checks and six monthly quality monitoring questionnaires. Spot checks were carried out during planned home visits by care workers and were used to identify areas of good practice and areas for improvement. This information was used to ensure individual care needs were met and to ensure care workers were well matched to the people they cared for. Supervisors spoke with people to ask about the service their care worker(s) provided and to ask about the reliability of care workers. This information was also monitored through spot checks.

Although the quality assurance process meant people had the opportunity to give feedback on their care, there was no evidence of learning. For example staff had not identified any areas for improvement or change in any of the 52 reviews and questionnaires we looked at. Where there were gaps in observations there was no indication action had been taken to address this. For example it was not noted in five spot-check observation records whether the care worker had signed their care plan entry or had said goodbye to the person as they were leaving. Another observation record did not indicate if the care worker asked the person what they wanted to eat and in a questionnaire the person noted the care worker was not wearing identification. All of the returned questionnaires indicated people felt care workers either usually or always arrived on time.

Care workers did not always have a clear understanding of their areas of responsibility in relation to safety. For example one care worker said there was no policy in place that detailed how to deal with situations in which they felt the relatives of people might be at risk of harm. For example they understood they were responsible for the people they were assigned to but felt that relatives in the same home could sometimes be at risk of harm. They said the organisation had not provided a clear answer about this and were worried that they may be reprimanded if someone was harmed.

The senior team recognised staff who were noted by multidisciplinary colleagues as providing excellent care. For example, social workers had recently identified four care workers who had provided an exceptional standard of care for people. Care workers told us this was motivational and helped them to continue looking after people to a high standard. In addition care workers said they felt the senior team recognised good work. For example one care worker said their supervisor sometimes left "well done" notes in care plans to let them know they had done a good job with record-keeping.

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 Care and treatment was not provided in a safe way for service users. The registered person did not have effective systems in place to mitigate any such risks to the health and safety of service users receiving care or treatment. Service users were at risk from the unsafe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Service users were at risk because their care records and risk assessments were not regularly checked to ensure they were of a good standard and reflected their current needs.