Radibor Limited

Availl (Norwich)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 21 June 2017 and was announced.

Availl Norwich provides a domiciliary care service in people's own homes. The service was supporting 14 people with their personal care needs at the time of this inspection. Availl Norwich also provided an agency service for temporary staff in residential care homes. However the Care Quality Commission (CQC) does not inspect or regulate that type of service. Availl Norwich supports older people, some of whom are living with different forms of dementia, people with physical disabilities and people with mental health needs.

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

At this inspection we found breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

People did not have thorough care assessments. The risks which people faced were not fully explored. People's care plans did not explain and guide staff about how to meet people's needs in a safe way. However, people told us that they felt safe when they received support from staff.

Staff knew how to identify if a person was experiencing harm or abuse in some way and knew to report this to the manager. However, staff did not know of outside agencies they could also report concerns to. Good practice was not always followed when responding to a safeguarding concern.

The competency of staff was not being checked on a regular basis and staff did not have a robust induction to enable them to support people effectively. Training was not always provided to meet people's individual needs. The service was not observing staff practice on a regular basis to check they were effective and supported in their work. Some people did not receive their medicines safely because this need had not been identified in their assessment of need. Staff did not recognise when systems were not in place to give people their medicines in line with safe practices and continued to administer them.

People were supported by staff who sought people's consent before supporting them. However, the service was contacting health and social care professionals on their behalf without obtaining people's consent to do this.

People told us that they received appropriate support with their food and drinks.

Staff were caring and kind to the people they supported. People also told us that staff treated them in a way which promoted their dignity and they respected their privacy. People had formed positive relationships with staff who supported them and they had confidence in the staff's abilities.

People told us that they saw regular staff, at times they were happy with, and they knew when and which members of staff would be visiting them on a daily basis. People did not experience late or missed calls. All the people we spoke with said they would recommend the service to others.

We found that people's care assessments and reviews were not always person centred. They did not explore people's needs adequately enough to enable staff and the service to know people's needs. The service did not have personalised plans in place to meet these needs.

There were insufficient systems in place to monitor the quality of the care and service provided. Audits were not taking place in relation to people's care records. The service had not taken sufficient steps in order to be confident, that people had robust risk assessments and reviews.

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

People's risk assessments did not fully explore the risks which people faced.

There were not effective systems, to manage some people's medicines.

There were enough staff to meet people's needs.

People said they felt safe with staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not given an effective and full induction when they started at the service.

Training was not provided to ensure staff had the knowledge to meet people's needs.

Staff were not given the guidance to meet people's individual needs.

The service had not fully explored people's consent in relation to accessing health and social care services, on people's behalf.

Is the service caring?

Good

The service was caring.

People were treated in a kind and caring way.

People's dignity and privacy was promoted by staff.

People and staff formed positive relationships with one another.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People's care assessments, reviews, and care plans were not reflective of their needs.

Staff training did not always reflect people's needs.

People told us that they received care relevant to their daily needs and wishes.

People were supported to avoid social isolation.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's care records were not being audited.

Staff competency was not being checked in a meaningful way.

There was no effective over sight of the quality of the service provided.

Availl (Norwich)

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.

The inspection took place on 20 and 21 June 2017 and was announced. We announced this inspection because this service provides a domiciliary care service and we needed to seek people's consent to speak with them. This inspection was completed by one inspector 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 viewed all of the information we had about the service. The manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team, local authority safeguarding team, and the clinical commissioning group (NHS) to ask for their views on the service.

During the inspection we spoke with three people who used the service and six relatives. We spoke with the manager, a care coordinator and five members of the care staff.

We looked at the care records of four people who used the service. We also viewed records relating to the management of the service. These included risk assessments, daily records, reviews, three staff recruitment files, training records, spot checks of staff, and audits.

Requires Improvement

Is the service safe?

Our findings

During our inspection of Availl Norwich, we found that people were not always supported to be safe, and improvements needed to be made.

The staff we spoke with all knew how to identify if a person was potentially experiencing harm or abuse in some way. These members of staff were aware that harm could be emotional as well as physical. They told us how they would spot the signs of potential abuse. All these members of staff said they would contact the office and speak with the manager if they suspected a person was experiencing harm in some way. However, out of the five members of staff we spoke with only one was aware of the local authority safeguarding team, who they could also report concerns to, if required. We asked one member of staff about other agencies outside the service they could also report concerns to, who said, "I honestly don't know." Another member of staff said they had a list of numbers on their introduction pack, which included this team's number. When they looked at this information, they told us that the local authority's safeguarding number was not on it. We looked at this introduction pack when we visited the office and confirmed this number was missing. We therefore could not be sure that staff had a full and detailed knowledge about how to report concerns outside of the service. We spoke with the manager about this who said they would amend this information and address this issue with staff.

We spoke with the manager about some cases which had involved some safeguarding concerns. In two cases the service had contacted social services to raise these concerns. However, there was another example when a person had made allegations about money going missing. The manager told us how they first spoke with this person's relative and then the person themselves. This was not good or safe practice in addressing a potential safeguarding issue. A referral to the safeguarding team should have been made and the manager should not have spoken with the relative.

During our visit we looked at people's care assessments completed by a member of the office staff who visited people in their own homes. These identified people's health needs, but the assessments did not always explore the risks people faced as a result of these health conditions. For example one person had "chronic depression," the member of staff assessing this person's needs did not explore what impact this had on the person. Another person had mobility needs, the risk of falling or developing a breakdown to their skin due to spending long periods of time sitting was not identified. Some people were diabetic and were being supported to manage their diabetes; the possible risks for these individuals were also not explored and identified.

People also had environmental risk assessments in place completed by a member of the office staff when they visited people in their homes. The purpose of this assessment is to identify any safety risks in people's homes which could affect the person or a member of staff. However, these assessments were not always robust and it was not always clear, if there was a risk or not. We looked at a sample of four of these assessments and three were not complete. One person had a physical disability, mobility issues and smoked cigarettes. Their assessment did not identify this as a fire risk. Another person had old electrical

equipment and "old wiring" and the assessment had also not identified if this was a fire risk. With the exception of one example, these risk assessments did not identify where a person's utility supplies were located. This information is important to support staff to respond to certain emergencies in people's homes. When safety issues were identified a plan should have been put in place to manage these risks.

We spoke with the manager about the lack of detailed risk assessments and clear environmental assessments. The manager later sent us an action plan which had identified actions about how to address these issues.

The manager told us that no member of staff administered people their medicines. We were told that in some situations staff prompted people to take their medicines. This risk was also not explored at people's risk assessments or reviews. These people's care plans did not guide staff about how to manage this risk should issues arise.

Despite the fact the manager had told us that people self-administered their medicines, we received conflicting information when we spoke with two people and a member of staff. One person's relative told us about the support staff gave regarding their relative's medicines. They said, "Yes, [relative] has tablets in the morning and at night when they [staff] come. I get some water for [relative] and they unlock the tablets and give them to [relative] in an egg cup and they [staff] always wear gloves as well. They are very careful when administering them; they [staff] are slow and make sure [relative] swallows them gently with the water." Also a member of staff told us that they called the office for assistance because, "The meds were all mixed up." As the manager understood the administration of people's medicines was not taking place, systems were not in place to monitor people received their medicines as the prescriber had intended. We concluded that there were times when staff were more involved in people's medicines and there were insufficient systems in place to manage the administration and or prompting of people's medicines safely.

We also found that there was a lack of guidance for staff to follow when prompting people's medicines. These people's care plans did not give information to staff about what they must do if a person refused to have their medicines. If staff suspected individuals were not taking their medicines.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment practices to see if these were safe. Staff had completed a Disclosure and Baring Service (DBS) check to ensure that new staff were suitable to work in a care service. All the staff we spoke with confirmed this check was in place before they started visiting people in their homes. We also reviewed a sample of staff personnel records and we could see that staff identities had been checked. Out of the three files we looked at two staff had two references. One member of staff had one reference. The manager told us why, but they had not sought another reference or spoken with this person's last employer. We noted that two members of staff records out of the three we looked at did not have full employment histories. This is another safety check to ensure people were safe to work in care.

The people we spoke with told us that they felt safe when they received support and care visits from staff. One person when asked said, "I most certainly do. They are so careful and gentle when handling me." Another person said, "Oh yes I do. They [staff] always ensure everything is locked before they leave." A relative told us that they felt their relative was safe, "Yes I do. [Relative] needs two carers as [relative] has a sling hoist. They [staff] are very careful manoeuvring [relative], and talk to [relative] to ensure they are happy and not in any discomfort when doing so."

People felt there was enough staff to meet their needs. One person said, "They [staff] are very punctual and we have not had a case when they have not turned up. They [staff] call if they are delayed in traffic." A relative told us, "They [staff] always stay their time even if they arrive a little late due to traffic. They [staff] never rush my [relative] at all, they are all excellent."

All the people and the relatives we spoke with said that they did not experience missed care visits and it was rare to have a late care visit. People also told us that they did not feel rushed and staff assisted with additional tasks. The staff we spoke with confirmed they did not feel under pressure to finish a call early and they went at people's own pace. The manager told us that they did not accept new care packages unless they had the appropriate staffing numbers. We concluded that there was sufficient numbers of staff to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

During our inspection of Availl Norwich we found that staff were not always supported to have the knowledge and guidance to do their job effectively. The manager was not always checking new staff were competent in their work after they had started working independently.

We looked at a sample of people's care plans and found these did not always contain sufficient guidance for staff to meet people's needs. Two people had complex moving and handling needs which required specialist equipment. People's plans did not outline what staff needed to do to ensure they supported the person to move from one position to another safely. These care plans stated, that staff are to ensure the equipment was safe to use before it was used. However, it did not give information to staff about how to do this. For two people who used catheters; there was no information to guide staff about how to do this. We noted on one person's daily notes that they were being supported to apply cream to their skin to prevent a breakdown of their skin. This person's care plan did not detail where to apply the cream to. Staff who checked a person's specialist mattress to ensure it worked correctly, but were not given information to guide them about how to do this. All the staff we spoke with said they looked at people's care plans to ensure they knew what their needs were and how they needed to support individuals. We concluded that staff had not always received the training, and support they required. In order for them to provide people with effective and safe support.

When we spoke with staff about their induction, we found they had not received training in areas which were relevant to the people they were going to be supporting. We spoke with one member of staff who had called the office because they were going to be supporting a person who wore a catheter, but they needed instruction about how to do this. They were told a member of the office staff, would give this instruction over the phone. Staff were supporting other people who used certain specialist equipment, but there was no specific training for this. Staff were supporting people who had diabetes and mental health needs and they had not received training in their induction in these areas. After new staff completed their induction training staff did not receive any further training, until refresher training was due the next year.

Staff told us that they received training in a series of subjects. These included infection control, fire safety, food hygiene, nutrition and wellbeing, safeguarding, and managing behaviour which challenged others. We were told this training took the form of watching a series of DVD's with a set of questions to answer at the end of the training. Staff told us that they found this a useful way of learning. Some staff said they could answer the questions during the training. One member of staff said, "It helped you to focus on the important issues." However, one member of staff said, it was "Exhausting," to condense the DVD training into one afternoon. The manager told us that they checked the new staff's answers to these questions before they started working at the service. We were shown records which showed that existing staff had received refresher training in these areas each year. However, there was no system in place to check later in the year, if staff had retained this knowledge.

Some members of staff did not shadow staff before they started to provide care independently. One

member of staff had not worked in a domiciliary care service before and was not offered a period of shadowing, they told us how they later encountered an issue using a person's specialist equipment and a further person's continence care. Another member of staff was new to the care sector and had two days shadowing. The shadowing process is also a system the manager can use to check staff competency and if individual members of staff needed further training.

The member of staff who told us that they did not receive any shadowing experience before they started working, also told us that they received a 'spot check' a week after they had started working independently. We spoke to another member of staff who had not received a spot check and had been working for the service since September 2016. We checked the spot check records which confirmed this. Spot checks are an important system the manager can use to see if staff were effective in their work and then offer additional training and support if there was a need to.

The staff we spoke with and the manager told us that staff received face to face training regarding medication administration and using some specialist equipment to support people to transfer from one position to another. However, staff did not receive face to face training on how to use a stand aid. We noted that two people's care records we had looked at stated they used this particular piece of equipment. Staff did not receive competency checks in people's homes, after the medication and specialist equipment training. This is important to check staff were following good practice after this training.

The above concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with said they felt confident and able to work independently in people's homes after their induction. They said if they felt they needed more support they would have asked for it. However, the purpose of these shadow shifts and spot checks are also to test staff competency and address training issues. Without these and with a limited induction programme for staff, the manager of the service could not evidence, they were confident staff practice was effective.

When we looked at the spot checks which were taking place, these records showed that staff were being asked particular questions. However, these questions did not check staff knowledge regarding managing people's individual needs and the risks they faced.

People told us that they felt staff were knowledgeable and skilled in their work. One person said, "Oh definitely. You can tell that in the way they move me around competently." A relative said, "I have full confidence in their skills."

Staff told us and we were shown records which confirmed that staff received regular supervisions during the year and had yearly appraisals. Staff told us that they found these meetings supportive and useful to their work.

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. We checked the service was working within the principles of the MCA.

When we looked at people's care assessments we noted that people did not have detailed capacity assessments. When people had mental health needs or a history of cognitive issues, the assessments carried out did not consider these issues and whether this affected a person's ability to make certain decisions at certain times. Or if staff needed to be mindful of this.

Staff told us and we saw records which stated that staff had received training with MCA . The staff we spoke with all said that they always gained people's consent before they supported them with personal care tasks. Members of staff also said they encouraged people to make choices with what they wanted to eat and drink and if staff were supporting people with social activities, with what they wanted to do.

The service had not sought consent on people's behalf, to share information or raise concerns with health and social care professionals. We saw records of the office staff contacting social service professionals, and there was no record that consent had been sought from people to speak with these professionals.

We concluded that staff were compliant with the MCA in relation to supporting people with their daily care needs. However, the service needed to improve how they assessed and reviewed people's abilities to make certain decisions. It also needed to make improvements about and how the service gained people's consent to contact outside agencies and professionals.

People spoke positively about the support staff provided with their meals and drinks. One person said, "They will make me something at teatime if I want anything, they always ask first, and on the late call make me a hot milky drink or again whatever I fancy." A relative told us, "Yes they [staff] get [relative] breakfast and at teatime get a meal out of the oven and take it to them. [Relative] can eat independently, but they do offer to assist if [relative] is feeling unwell when they come."

The staff we spoke with were able to tell us what people liked to eat and drink. We could see in people's care records that people had been asked about what their food and drink preferences were. However, this information had not been reviewed for some time. People told us that staff offered them choices and checked they had sufficient food at home. One person said, "They also always look in the fridge and freezer to make sure I have enough food in the flat and even put bread out to defrost."

People told us that staff responded to a change in their health needs and took action. One relative said, "Availl pick up on anything that doesn't seem right. For instance if they find [medical issues] they [staff] immediately tell me and advise me, if I need to tell the district nurse or my doctor." Another person's relative said, "[Relative] had a bought of [medical condition] and they ensured help was called for and left a word for the district nurse when they came in." Other people and relatives we spoke with had confidence that the staff would share concerns and take action if there was a need to.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the staff being caring and kind.

We spoke with one person who said, "I cannot fault it. I have no complaints. They are all first class, polite and caring and chatty, which I like. They are very slow and careful with what they do with me. Every single carer is kind and willing." Another person said, "They are like family. All the carers are lovely, kind, polite and we have a good chat and lots of laughs when they come. I am very happy with Availl with everything." A relative said, "Quite good I am very happy with them. I have no complaints, [name of member of staff] is excellent, chatty and polite and very caring in what [they] do with helping my [relative]."

The people and their relatives who we spoke with confirmed that they saw regular staff, at the times they had requested. People felt listened to and supported by the staff and service. People had formed positive relationships with the staff who supported them. For example one person told us, "One carer even phoned the office to ask if [they] could get some shopping in for me as I was low and can't get out, and they agreed straightaway. Anything I ask for they will see to it for me." Another person said, "Oh yes. If I ask them to get my washing in they do and get it off the line. They will do anything for me and I find that very comforting."

The staff we spoke with described the relationships they had made with individuals who received care from Availl. Staff told us how they listened to what the people wanted. Members of staff also said they chatted with the person and assess how the person is that day and they respond appropriately.

People and their relatives told us that staff show concern for people's wellbeing and responded appropriately. "They always stay their time and never rush. I recently had a situation when I had to call for an ambulance for [relative] and they [member of staff] insisted to stay with [relative] until it arrived, which they did."

We spoke with a member of staff who told us about one person they supported, who liked to talk about their own relatives to this member of staff. They told us how sometimes this could also make the person emotional and upset. They told us how they supported this person's need to talk about their relatives and how they responded when they become distressed about this. This member of staff said, "Sometimes I dance, I sing, talk about the Queen, I distract them from feeling sad or depressed."

People told us that they were involved in the planning of their care. One person said, "Yes I do that with them." Another person told us, "Yes me and my son and daughter do that with them." A relative also told us that, "I have to see to that for [relative] as [name of person] isn't able to." People told us that they received calls at times they had chosen or were happy with. People also said that they were supported with tasks, that they wanted assistance with.

The people and their relatives we spoke with told us that staff always treated them in a respectful way and promoted their dignity. One person said, "Most certainly I have no concerns around that at all." Another

person said, "Definitely." A relative also said, "I'll say. When they wash [relative] carers ask if [relative] would like the blinds closed. We are on the 8th floor. I don't think the seagulls would mind. But it shows they are fully respectful."

Staff told us how they promoted people's privacy and dignity when they were supporting people with personal care. All the staff we spoke with said they asked people what support they wanted before they assisted them. Staff gave examples of leaving the room to give people privacy at times and then asked if they could re-enter the room to assist them further. We looked at a sample of people's daily notes written by staff. Staff had written sensitive information here in a respectful and polite way.

The manager told us that staff received training on confidentiality. Staff told us that people's care records and care plans were kept in a, "discreet place" in people's homes. When we visited the services' office people's confidential information was stored in a secure way.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives who we spoke with felt they received care which was personal and individual to their needs. However, people's care assessments and care plans were not always person centred.

During our visit we looked at a sample of four people's care assessments and care plans. We found that these were not consistently person centred. We could see from looking at these documents that people had initially been involved in the planning of their care. People were asked what time they wanted to get up and what tasks they wanted support with. Alternatively, we also noted a lack of information in people's care assessments. For example information about the tasks people wanted to be independent with was limited or not present. What people's daily care routines were, and how they wanted these carried out was often not recorded. There was limited information regarding people's interests, their past experiences and achievements. Some people were living with mental health needs and cognitive conditions. How people's emotional needs impacted on their daily needs was not considered.

However, people told us that staff did respond to their needs. Staff confirmed that they chatted and got to know people and they asked them how they wanted to receive the support identified at their assessment. People told us that they wanted to see regular staff at certain times and to know what members of staff would be visiting them a week in advance. People told us that, without exception, this was happening.

We concluded that the actual care people received was person centred and relevant to people's individual daily care needs. However, people's care assessments and care plans were not consistently person centred. There was a lack of personalised guidance for staff to follow. This is important because there may be times when people are supported by staff who are not their regular member of staff. We spoke with the manager about this. They sent us an action plan which identified this issue with a plan of action to improve the planning and assessment element of people's care.

During our visit we identified issues with how people's needs were being reviewed. The manager told us and we could see from looking at people's care records that people were having frequent reviews of their needs. This would be conducted face to face and if people agreed this took place every three months. However, the review records were not detailed or sufficient to demonstrate a full and robust review had taken place, which had involved the person as much as possible. We looked at a sample of four records and consistently found statements such as "no change" written on these documents. The form used stated that people's views had been asked. We could also see when the service was completing spot checks; people were being asked what they thought about the care they were receiving.

We also found that two people were being supported by staff who administered their medicines. The service was not aware of this. We discovered this by speaking with people and asking them how staff supported them with their medicines. The fact this had not been previously identified at people's reviews made us question, if the reviews were consistently robust.

We concluded that people were being asked about their views about the care they received. However, the way this information was recorded and documented required improvements to be made.

We spoke with one person who told us, "Most definitely. They cannot do enough for me, always asking if I would like anything else doing and whatever I ask they do." Another person said, "At lunchtime I have prepared meals. They always ask what I fancy and sometimes I say surprise me, so they make the choice. We have a good laugh when I say that."

People were supported to avoid social isolation. The people we spoke with told us that staff chatted and spent time with them whilst they completed care tasks. The staff we spoke with said they always started a call chatting to people and to check how they are. One member of staff said, "I always ask, how was your night?" When we looked at a sample of people's daily notes we could see that staff had recorded they had spoken with the person and spent time chatting to them. The people we spoke with confirmed this was happening daily, when they saw staff. The staff we also spoke with said they would address with the person and office if they had concerns if a person was socially isolated. One member of staff said, "I would give them information about coffee mornings and lunch clubs." The staff we spoke with said they were mindful of this issue when they visited people.

We asked people if they knew how to raise a complaint or any concerns they had about the service. People told us that they would contact the office. Some relatives told us that they had raised issues with the office and these were dealt with quickly. All the people we spoke with said they had not made any formal complaints, but they had confidence, that if they did, it would be addressed appropriately. We were shown a compliments and complaints folder. There were some historical complaints which we could see the manager had addressed at the time. The manager showed us the result from a recent survey about the service. The results were positive.

Requires Improvement

Is the service well-led?

Our findings

We found some positive elements with how Availl Norwich was being managed, but we also found some areas which were not well led and required improvements to be made.

We found short falls in the service's quality monitoring systems; these were either non effective or not taking place. For example we looked at a sample of people daily notes, the manager told us that they had audited these, but they had not recorded that they had done this. We found an issue with one person's daily notes. A health professional had left a message for staff to take certain action regarding a person's health needs. We noted that some days had passed before a member of staff had taken action. We also noted some references to the person later saying they felt unwell. There was no record of what action or advice this member of staff had given this person. We saw references in other peoples' daily notes that staff were completing care tasks which were not detailed in people's care plans. Had an effective audit been completed these issues would have been identified. We spoke with the manager about this and concluded people's daily notes were not being audited. This meant that any shortfalls in peoples care were not being identified and acted upon in a timely way.

We looked at a sample of four people's care assessments, care plans and reviews. We found shortfalls with all of these documents. The risks to people were not fully explored to ensure they were safe. At times it was unclear if environmental risks were present. People were not having meaningful reviews of their care to ensure it remained appropriate and satisfactory. People's care plans did not fully identify people's needs and guidance for staff to follow to meet these needs was not sufficient. These records were not audited to check these were effective documents. We found that staff who completed these documents did not have the training or skills required to do so.

People and staff told us that 'spot checks' which checked staff competency were not regular events. The records we looked at showed these were happening on an infrequent basis. The spot check forms used did not prompt office staff to observe the interaction between the member of staff and the person. It did not check whether safe moving and handling techniques were being used. Staff were not being asked about their knowledge of important areas such as safeguarding practices. Two people told us that staff were administering people their medicines, but the manager was not aware of this, and did not have systems in place to manage this. The records of spot checks were also not being audited to check they were robust and appropriate action was being taken, when issue were identified.

We found at our last inspection and again at this inspection that staff were not receiving training in areas which were relevant to the people the staff supported. People had certain health conditions and mental health needs which required staff to monitor and respond to these. However, staff received no training in these areas.

At this inspection we identified that staff were not having their performance checked before they were working independently in people's homes. The only system used was a test following a period of DVD training. Staff received a competency check regarding medication administration and prompting, but this

took place in the class room and not in people's homes. Staff did not receive a competency check relating to moving and handling techniques, in people's own homes. The training provided with supporting people to transfer from one position to another did not include 'stand aids' and yet we noted that some people needed to use this type of equipment.

There was a lack of auditing regarding people's care records and the lack of regular and robust competency checks relating to staff practice. Therefore we concluded that the manager could not ensure that people were receiving safe and effective care. Good and safe practice had also not been followed when a person who used the service made allegations of a safeguarding nature.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed with the manager about the important events they must notify the Care Quality Commission (CQC) about by law. The manager advised us about the events they must notify us about by law including safeguarding concerns. We were told of a safeguarding event which involved social services but we were not informed of this.

The above concerns constituted a breach of Regulation 18, the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

People said that they felt confident in contacting the office to discuss issues. However, they did not know who the manager was. Most people had assumed a member of the office staff was the manager.

All the people we spoke with said that they would recommend the service to other people. One person said, "I trust them with what they do, any issues they respond well, the carers and team are excellent, yes I would recommend them." Another person said, "Yes I would recommend them. They look after my [relative] well."

The staff we spoke with said they had confidence in the manager and felt supported by them. Staff received regular supervisions and yearly appraisals. One member of staff said, "The supervision is good, it makes us feel that the agency cares about us too." Staff said they felt confident about raising issues relating to the people they supported and any issues with their colleague's practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Care Quality Commission (Registration) Regulations 2009 (Part 4): 18 Notification of other incidents. The registered manager had failed to notify the commission about important events which they must notify us by law. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The manager and provider had failed to ensure that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. People's medicines were not always managed safely. Regulation 12 (1) and (2) (a) (b) (g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance

The registered manager and provider of the service did not have effective systems and processes in place to monitor and improve the safety of the service provided.

Regulation 17 (1) and (2) (a) (b) and (c).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The registered manager of the service had not ensured that staff had received appropriate support and training to do their work. Regulation 18 (1) and (2) (a).