Wealden Community Care Limited

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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

We inspected Wealden Community Care Ltd on 02 and 06 December 2016. The inspection was announced so that we could ensure people and records we would need to see were available. Wealden Community Care Ltd is a domiciliary care agency registered to provide personal care for people who require support in their own home. The organisation is registered to provide care to people with a learning disability or autism spectrum disorder, dementia, older people and younger adults. At the time of our inspection Wealden Community Care Ltd were providing care to 160 people who had a range of needs from old age, cerebral palsy, dementia, mental health, Alzheimer's disease and end of life care. The service employed 55 staff and one office manager. The registered provider had four care co-ordinators who manage a geographical location of care calls. The registered provider used an electronic tracker where carers log in and out of care calls using a telephone line.

At the time of our inspection there was a registered manager at the service but they were no longer in day to day control. 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. However, the registered manager confirmed they would de-register and there was an acting manager who was in the process of registering with CQC.

People were protected from the risk of abuse but were susceptible to the risk from avoidable harm. For example key safe number s had been emailed to unsecure email addresses. Risks were not assessed comprehensively and where hazards had been identified these had not been mitigated fully. Medicines were not effectively being managed as the recording sheets used did not contain information about each medicines and prescribing instructions. In addition this information was not contained on any other part of the care plan.

Recruitment procedures were not consistently being followed and staff had not always had the correct pre-employment checks prior to working with people.

People had access to healthcare professionals but they were at risk of not having their health needs met as information was not consistently updated. For example one person had important changes to how staff should support them to eat and drink but these had not been included in the care plan three months after the changes had been made.

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not consistently been complied with. Two people were being supported with the use of bed rails but the registered provider had not considered whether the use of bed rails was restrictive. Care plans did not always have consent forms signed by people or their representatives.

Care plans were not consistently person centred and did not always contain the person's 'voice' or their

input. One person's care plan had failed to mention a diagnosis of mental health problems and how best to support the person in this area.

Quality monitoring systems were not effective in identifying shortfalls in the service and the current system had not been reviewed on a monthly basis as per the system requirements.

The staff were kind and caring and treated people with dignity and respect. Caring relationships were seen throughout the day of our inspection. Staff knew the people they cared for well. People spoke positively about the care and support they received from staff members.

People receive adequate food and drink and where necessary the registered provider uses food and fluid charts to monitor how much people are consuming. However, some records were not always complete and some plans lacked detail about people's food preferences. We have made a recommendation about this in our report.

Staff were well trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly. Staff were supervised and had annual appraisals. However, these did not contain targets or much detail about performance. We have made a recommendation about this in our report.

Complaints were logged and responded to in line with the registered provider's policy. However, not all complaints were handled in a person centred way or used as a tool for improving service delivery. We have made a recommendation about this in our report.

Care plans ensured people received the support they needed in the way they wanted. However, people's preferences and views about their care were not always recorded. We have made a recommendation about this in our report.

The culture of the service was supportive to staff members. The management team provided leadership to the staff team and was an active presence in the service.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers 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 consistently safe.

People were protected from the risk of abuse but were not always protected from avoidable harm.

Risk assessments were not comprehensive and did not demonstrate effective control measures.

Staffing numbers were sufficient to meet people's needs.

Medicines were not managed safely. MAR sheets did not list individual medicines, prescribing instructions and were not signed in.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained to carry out their role.

Consent was not always being sought in line with the principles of the MCA, e.g. bedrails were being used with no capacity assessment.

People received adequate food and drink and where necessary had food and fluid charts in place.

People had access to healthcare professionals but their healthcare needs were at risk of not being met due to out of date information in care plans.

Is the service caring?

Good

The service was caring.

Staff knew people well and had fostered good caring relationships with people.

People felt they were given a choice but it was not always clear they had been involved in planning their care.

People are treated with respect and their dignity and independence is upheld

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always person centred and did not contain important personal information, such as diagnoses.

Complaints were not always used as a tool for improving services.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The culture of the service is open and supportive and the acting manager pro-actively seeks ways to support staff.

The management team provided leadership to the staff team but the registered manager needs to de-register and the acting manager needs to register as manager.

Quality monitoring systems were not effective in identifying shortfalls in service delivery.

Wealden community Care Limited

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 02 and 06 December 2016 and was announced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. 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 also spoke to the local authority quality team to gather their feedback.

As part of the inspection we spoke with the acting manager, office manager, three care co-coordinators six carers, 34 people using the service and two people's relatives. As some people who received a care package from Wealden Community Care Ltd were not able to tell us about their experiences, we observed the care and support being provided to three people with pre-obtained consent. During these home visits we were accompanied by a care worker. We looked at a range of records about people's care and how the service was managed. We looked at nine people's care plans, medication administration records, risk assessments, moving and handling assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Wealden Community Care Ltd when they were registered at a different address, in August 2013 when we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People were protected against the risks of potential abuse and those receiving care from Wealden Community Care told us that they felt safe. One person who is hoisted by their carers told us, "Yes, I feel quite safe. I know the person who trains them: I trust them." Another person who also used a hoist commented, "Yes, I feel safe. They put a big strap so you can't fall out."

People were protected against the risks of potential abuse. One staff member told us, "I've had safeguarding training. Any concerns I would report those to my manager." Another member of staff commented, "I've never had to raise a SAAR [Safeguarding Adults At Risk] alert, however, if I had any concerns I would talk to the office manager." One member of staff told us the safeguarding training was brief. We asked to see the records for training and could not see separate safeguarding training recorded on the training records for many staff members. When we raised this with the acting manager we were told that safeguarding training was delivered with Deprivation of Liberty Safeguarding (DoLS) training and this was why it was not recorded.

We recommend that the registered provider reviews their training recording system to ensure all training is clearly recorded.

However, people were not always kept safe from avoidable harm. For example, the codes for key safes attached to people's properties were sent out in rotas to staff members via staff members' own private email addresses. One carer told us, "Key codes are sent within the rota. They are not sent in coded form." This meant that people's personal data was not kept as safely as possible. When we raised this issue with the acting manager we were told the registered provider will review this practice. People were not always being protected against risks and action had not been taken to prevent the potential of harm. We examined several risk assessments and found that they did not consistently identify possible risks. For example, one person had oxygen in their home to assist them with their breathing. However there was no consideration given to the potential fire hazard from oxygen in the environmental risk assessment, only that the lead could be a trip hazard. Risk assessments were also lacking in detail. Another person had a risk assessment that identified that their pet uses the shower as a litter tray; however, there were no actions or control measures recorded as to what staff members should do to reduce the risk, stop it happening or to promote infection control. Another person's risk assessment identified that they were living with a degenerative disease which affected their speech, mobility and continence. However, there was no mention in the risk assessment around how to offer support to the person with their continence needs or what control measures were needed to ensure the person could mobilise safely.

The registered provider did not ensure that ensure that people were kept safe from risks or avoidable harm. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Staffing numbers were not consistently sufficient to meet peoples agreed care packages. People had been assessed and a level of care had been agreed upon between the registered provider and local authority or the person funding the care if it was privately funded. Most people were receiving the level of care that was being funded. However, one person had been assessed as requiring two staff for four care calls a day. This

had been agreed by the local authority that was funding the placement. The person required two carers due to their health condition and their mobility problems. The person's moving and handling assessment had stated that two female carers who were not pregnant and who were fully trained were required to provide support. The person's risk assessment also detailed the need for two carers to support the person with mobility. However, when we checked the care records for this person we found that out of 10 days' records we examined there were nine care calls (out of 40) where only one carer had delivered care. The care plan from the local authority also stated two carers were required to safely support the person. We raised this with the acting manager and were told, "Only a handful of carers will do that call by themselves. I have assessed them as competent to do so. They are NVQ level two trained. As X has an overhead hoist, care can be delivered with only one care staff. However, for other care calls we send two staff as I feel comfortable sending two carers due to the care needs of X." We spoke to the local authority who told us that if a care package can be safely managed with one person they would expect the provider to refer the package for reassessment. We reviewed the persons' notes and their package was reviewed in October 2016 and a decision was taken to increase the morning and lunch calls to one hour due to the person's needs. There was no reference to any variation in staffing and all calls are recorded as requiring two staff. There was no evidence to demonstrate that a referral had been made for assessment and no evidence to demonstrate why it is safe and in line with the agreed package of care to only send one carer. We raised this with the acting manager and were told, "The care is performed by senior staff who have been individually taught by the moving and handling trainer and who have attained a NVQ2 level or higher or have a risk assessor qualification".

We recommend that the registered provider reviews care plans to ensure that people's assessed needs are being reflected in their care plans and their assessments.

Safe recruitment practices were not always followed before new staff were employed to work with people. On completion of a successful interview new staff members were asked to provide two references and to provide an employment history. Criminal records checks had been made through the Disclosure and Barring Service (DBS) but one staff member had started working at the service before it had been established that they were suitable. An email had been received by the registered provider to state that a DBS check had been made for the member of staff but it did not state whether the check was clear or not. A DBS was issued later that was not clear and which indicated a risk to others. We asked to see the risk assessment for the member of staff working with vulnerable people and were told there was not one. The acting manager told us that the new member of staff would have worked shadow shifts until the DBS came back. Paperwork in the staff members' file demonstrated that they were shadowing on three shifts in May 2016. However, rotas we saw reflected the fact that the person was working alone before their DBS had been received. Other staff files we looked at showed that people had two references and a DBS check on file.

The registered provider did not ensure that ensure that safe recruitment procedures were followed. This is a breach of Regulation 19 of the HSCA Regulations 2014.

Medicines were not consistently being managed safely. The acting manager had conducted medicines audits to look at errors. The errors had been categorised as medicines not signed for and creams not signed for. For example on 4th October 2016 eight different carers had been responsible for not signing 25 medicines. The acting manager had taken action to put this right as part of the audit. However, the audits did not identify that medicines administrations records (MAR's) were not being completed correctly. For example, one person's medicine was recorded as, "Oxybutynin" and on another week it was recorded as "Oxybutynin 1 tablet daily". Neither of these entries were signed in by a member of staff and there was no running total or stock check, which meant that it was difficult to track if any medicines were missing. There were not full and accurate entries made on the MAR sheets to indicate which medicines were prescribed for

the person, when they must be given, what the dose was or any special information, such as giving the medicines with food. Where people had medicines delivered in blister packs from a pharmacy, staff members who were supporting people with their medicines were recording, "blister pack" on the MAR to say the medicines had been given. However, there was no corresponding record to say what was contained in the 'blister pack' (as documented on the MAR chart) covering the administration dates of that chart.

We accompanied a care worker on three visits and looked at people's medicines to see how they were being managed in people's homes. Medicines were not being safely managed in people's homes. We saw creams that had been opened but did not have a date on them to say when they had been opened so that staff would know when they would expire. One person had a dose of their blister pack tablets missed. The tablets were still in the blister pack from the previous Friday and there was no record in the care plan or on the MAR sheet as to why they had not been administered, and what action had been taken. We asked the carer we were shadowing what had happened with the dose and what would normally happen if a dose had been missed. The carer told us, "Normally we let the office know that's standard procedure." The carer was unable to identify why the tables had not been given. We raised this issue with the acting manager and subsequent to our inspection we were told that the carer had called the issue to the office and that the carer couldn't give the medicines as they arrived at 12.17 and the person had had their morning tablets at 10.36 (there needed to be a four hour gap). The acting manager told us they would, "Contact the doctors again to advise them of (person's) late morning call and it is impacting on the lunch time meds." However, this incident had not been recorded fully as an incident and reported to the person's GP and the local authority. Another person's care plan stated that due to the person's complex health needs and the importance of having the correct medicines, "X self-medicates but carers to ensure medication is taken correctly." However, the daily notes did not indicate that carers were checking whether medicines had been taken as per the care plan. We spoke to a carer who told us, "We don't touch meds at all as she's quite competent to do it," This leaves the potential for any unintended medicines errors to cause harm to the persons' health and also meant that either the staff were not following the care plan.

The registered provider did not ensure that ensure that medicines were managed safely. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "The carers are very nice, they're always very kind to me", "I've had three lots of agencies but this one is the most brilliant one I've had" and "The staff know what to do every time and there's no language barriers."

People had access to healthcare professionals but they were at risk of not having their health needs met as information was not consistently updated. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. One person had been assessed by a speech and language therapist as needing a special soft diet due to their risk of choking. The person also required the use of a drinking straw and was to be encouraged to take small sips of their drink when taking fluids in order to take food and fluid safely. However, the person's care plan was not updated to reflect these changes, meaning that staff members would not have up to date information on how to safely support the person to eat and drink. We spoke to the acting manager and were advised that the care plan was due to be updated. The acting manager also told us that staff had been informed verbally of the changes. However these changes were identified in October and by the 2 December 2016 the care plan still hadn't been updated.

Other records were not being kept up to date which meant staff members did not have the most recent information to support people with their healthcare needs. Two people with complex health needs were assessed as requiring support to mobilise. Both people required a hoist to assist them when transferring from different locations, such as from their bed to their chair. One person had a moving and handling assessment completed in May 2015 that was due for review in October 2016. However, there had been no review of this assessment. In addition both people's assessments failed to mention critical details such as which sling size was to be used and which coloured loop on the sling should be attached to the hoist for a safe transfer. As a result carers would not have the correct information on how to support people to move.

The registered provider had not kept complete and contemporaneous records for each person. This is a breach of Regulation 17 of the HSCA Regulations 2014.

Consent had not consistently been sought and the principles of the Mental Capacity Act 2005 (MCA) had not consistently been complied with. The Mental Capacity Act 2005 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 whether the service was working within the principles of the MCA . Staff members understood that some people may not be able to consent. One staff member commented, "Always ask [for people to consent], however I don't ask large open ended questions; I ask questions with a yes or no answer." Some people's care plans had consent forms in place. For example one person had a signed form to consent to staff members applying topical creams to their bodies. However, we also saw that two people had bed rails. In both cases the local

authority had assessed each person and had put the bed rails in place. However, the registered provider hadn't identified that the use of bed rails could potentially amount to a restrictive practice. The registered provider was unable to demonstrate that either person had consented to the use of bed rails and had not completed their own MCA assessment or considered the person's capacity to consent to the use of bed rails.

The registered provider did not ensure that consent was sought in line with the Mental Capacity Act 2005. This is a breach of Regulation 11 of the HSCA Regulations 2014.

Staff told us they had the training and skills they needed to meet people's needs. Comments included, "I've done a NVQ (national vocational qualification) in team leadership and I'm doing NQF (national qualification framework) course level 2 which covers medication, end of life care, diabetes and the mandatory training." Another member of staff told us, "I've recently done dementia, catheter care, EOL and safeguarding. I'm also doing NVQ level 3." A third staff member commented, "I've done my NVQ level 2 and I've recently done diabetes and dementia training." Another staff member told us, "The training is really good, I've had training on catheter care, dementia, moving and handling and done an NVQ in customer services." Staff had appropriate training and experience to support people with their individual needs. There was a training plan in place to ensure staff training remained up-to-date. This system identified when staff were due for refresher courses. The acting manager monitored staff training needs and scheduled training courses for staff. Staff were able to request extra training courses. We saw that where people needed specific or specialised support their staff team were trained in these areas. One person had a catheter and their staff team were trained by a nurse in how to use the catheter. Staff members were offered development opportunities through training. The acting manager told us that all new staff are offered Qualifications and Credit Framework (QCF) training level 2.

People were supported to have access to sufficient food and drink. People felt that they were supported well with their meals. One person told us, "They get my breakfast in the morning. They wash their hands and a different apron on." Another person told us, "They give me breakfast in the morning. I do dinner and they pop in to see I have it okay. They wash their hands. They have been well trained." Another person told us, "They [staff members] just help me with lunch. They put it in the microwave. They wash their hands always." Staff members told us that some people are at risk of not eating or drinking a sufficient amount to maintain good health. Where this was the case staff members would use food and fluid charts to record how much people had eaten or drunk. We viewed the food charts for one person when we attended their care call. The food charts had been partially completed and where entries had been made they matched the daily care records. However some entries had been missed and were left blank by care staff. Support plans recorded where people needed assistance with their food and drink. For example one person had a preference for a particular brand of milkshake and staff members were directed to make a milkshake and leave it available for the person twice a day. However, some care plans did not have the sufficient level of detail when describing what food people like or dislike. For example one person's care plan directed staff members to "make a light snack" but did not contain any specific details such as whether the person liked sandwiches, white or brown bread, or whether they had any particular dislikes. None of the care plans we reviewed contained much detail about people's preferences around food.

We recommend that the registered provider reviews all care plans to ensure that all records relating to food intake and preferences are complete and contain detail.

Staff members received an effective induction and had demonstrated their competence before they had been allowed to work on their own. The acting manager had implemented the 'Care Certificate' training to be used with all new staff since April 2015. This is based on an identified set of standards that health and social care workers adhere to in their daily working life. It has been designed to give everyone the confidence

that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. The Care Certificate was developed jointly by Skills for Health, Health Education England and Skills for Care. Staff members had access to supervision and appraisal. Some supervisions were conducted as spot checks to test staff members' knowledge around areas such as their knowledge around safeguarding and what the staff members know about the MCA. Supervisions were also conducted formally and were held between staff members and a more senior employee. Appraisals were held annually between the acting manager and staff members. However, the appraisals we saw did not contain much detail or provide a great deal of feedback to staff members. For example instead of recording feedback or setting goals the appraisals instead used a tick box system to indicate whether the staff member was excellent, satisfactory or average for areas such as attendance or initiative. As such, the appraisals did not highlight areas for improvement, set goals for the coming appraisal period or assess the overall performance of staff.

We recommend that the registered provider reviews the system used for appraising the performance of staff members.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "They are kind to me. I find them great. They just talk to me and treat me normally. You wanted to be treated as a normal person." Another person told us, "Yes. My walking is very poor and my breathing is bad as well and they are always there behind me saying 'you take your time, we have the time to do it'." A third person told us, "They are kind and caring people and one always gives me a hug when she leaves. We have become friends. We laugh so much. Talking is medicine in itself." A care co-ordinator told us, "I feel the carers have time to sit and chat with the clients: I do during care calls. Once you've done everything, I always sit down for a chat."

People received care and support from staff members who had got to know them well. The relationships between staff members and people receiving support demonstrated dignity and respect at all times. We observed good interactions between people and staff who consistently took the time to ask people's permission before intervening or assisting. One staff member told us, "I like talking to everyone. It's like having history lessons listening to their stories. They are like my family now." Another member of staff told us, "We have one person who is undergoing a test for dementia. They were really against us at first. However, over a period of time, they have become familiar with us and the routine. We explain to them what's going to happen, or say what we usually do." We observed warm interactions between people and their care staff.

People clearly knew their care staff and staff members knew people and their homes well. One staff member was able to find the ashtrays for one person who was experiencing confusion and another staff member had a friendly chat with a person about that person's extended family. The person clearly enjoyed the familiarity of being able to talk at ease without having to explain who people were in the story. Another person was experiencing confusion and commented to their staff, "I keep thinking I need to go home but this is my home?" The staff member crouched down to communicate at eye to eye level with the person and asked, "Is it not feeling like it? It has got all your lovely things" and proceeded to show the person their photographs and talk about their belongings with a good level of knowledge of what each thing meant and who was in the photographs. This sensitive support put the person at ease and they ended the interaction by saying, "Let's have a lovely cup of tea: a London cuppa", which was a shared joke between them and their carer.

People's privacy and dignity were respected by staff. One person told us, "Yes they respect my privacy and dignity. When I go to the toilet, they are behind the door and are there to help if I need it." Another person commented, "Definitely [they respect my privacy and dignity]. They cover me up if they hear anyone's coming into the house." A third person told us, "Yes I have a man in the night. He is a very nice man. I have never asked for female carers." Another person told us, "They ask me what I would like them to do: I could not wish for a better lot." When staff members had finished a call they would routinely ask people if there was anything else they could do and reassured people that nothing was too much trouble: people appreciated this interaction and responded by making the comments, "Look after yourself and I'll see you tomorrow" and "Bye my love see you this afternoon." These interactions, coupled with peoples' body language displayed that people's moods were lifted after they had received care from staff members.

People were supported to maintain their independence. One staff member told us, "I go to one lady who is in her early 90s. She is fiercely independent. I help her to retain that independence. I encourage her to do what she can and only provide support with tasks that she struggles with or is unable to do, for example, cream her legs." During our time shadowing care calls we observed a high level of interaction between people and their care staff. One person who was living with dementia was supported to change their clothes to more seasonally appropriate wear. We could hear the person was being offered a choice and encouraged to not only choose their clothes but to do as much as possible for themselves when they were putting their clothes on.

People told us they were given choice in their day to day care. One person told us, "They offer me choices. I don't have any problem about that at all." Another person told us, "If I want choices then yes they offer me choice." A third person commented, "They ask me all the time what I want and they never just assume." However, care plans did not consistently show peoples' involvement in planning their care. The care plans we looked at had sections for people to sign and in some cases these were signed. However, some care plans were out of date and some care plans gave no indication that people had been involved in planning their care.

We recommend that the registered provider reviews care plans to ensure that people's choices and input in to their care are reflected in their care plans.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not consistently person centred and the users' voice was not always included. Some care plans we viewed contained good personal information. One persons' plan gave good detail about the person's interests and how to support the person. The plan explained that certain tasks were always to be completed by the person's mother but then detailed what carers were expected to do, such as to apply topical creams to the person to maintain their skin integrity. The care plan gave a good description of the person's preferences, "X enjoys music of all sorts and attends concerts, particularly outdoors concerts. X is interested in steam engines and attended Dorset steam fair. X also likes heavy horses and watching horse trials. X enjoys watching DVD's and uses internet sites. X communicates by eye to eye contact and enjoys verbal communication and participating in his way." Carers would have a good idea of the unique personality of the person and their interests from this plan.

However, other plans lacked important personal details. One person's care plan was not person centred as there was no evidence of involvement from the person. There was no clear management plan in place to manage an issue of self-neglect in relation to the person not emptying a cat litter tray. In addition there was no up to date risk assessment in relation to medicines, management of falls or their mental health needs. Furthermore the care plan failed to reflect that the person had mental health needs and a learning disability. This information was only seen in an older NHS document in the persons file. Another person's care plan contained inaccurate information. It stated, "X can mobilise fairly well but needs help with meal preparation and personal care." However, it later stated, "Currently X's speech is slow and a little slurred, they cannot mobilise well." We looked at the person's moving and handling assessment and it was stated that they required assistance to move but there was no detail about how this should be done. Another person's care plan spoke about the person being non-compliant around personal care. It spoke about carers knowing when to stop as the person's mood can change quickly and can lead to aggression. However, there was no detail about key words or phrases to use, or avoid, about routines that may help the person, and there was no positive behaviour support plan to help the person manage their anxiety.

People did not consistently tell us that they had a person centred service. We spoke to people about their care and asked if their care calls were consistent and at times that they wanted. One person told us, "I do sometimes get a phone call [if carers are late]. It's very rare they have to change the times. At the moment, more or less the times suit us. They are quite busy in the mornings and sometimes they run over. I don't receive a rota." Another person told us, "I ring them up and ask what times they are coming. My hand is very shaky to write it down and they don't always keep to the times they are supposed to be coming. I just have to accept it [the times]. I prefer it at 8.30-9 a.m. but one day is 11.30 a.m. I did ask that this Friday be earlier; any special reason and they try to help." Another person told us, "This last Sunday they arrived at 11.20 a.m. to get him up. Very often there is a 10.15 a.m. call and they don't get there until 11 a.m. There is no fixed time. We would like 8 to 9 a.m. but can't get an early morning call. Because they are so late I have to do the stoma and catheter. My husband is also diabetic. Last Thursday was down as 3 p.m. and the carer was in the office doing paperwork when I phoned at 5 p.m. She arrived at 5.30 p.m. Even the girls say it's not very good. The programmes are not done well. An example is girls being sent 8 miles away and others from that area being sent 8 miles to here. I think they need to get more staff. I could do with somebody on time. I like to

know when people are coming, or leaving. It makes things awkward. My husband gets fed up with sitting in bed. I have no quarrel with the girls, who are compassionate."

We received mixed feedback about the punctuality of care calls. One person told us, "Sometimes they are a bit short of staff so they are a bit late. They generally ring me up to say. It's not very often they are late. Not with this lot". Another person told us, "Last night it was 11 o'clock before they came. They did phone me up last night. They don't always phone when they are coming late." We checked through the records to see if staff were making calls at the times people expected. We analysed the call times for one person from their daily notes. The morning and lunch time calls seemed to be delivered in line with the agreed times on the persons' care plan. However, tea and bed time care call varied greatly from the agreed time. The care plan stated that the person's tea call should be between 16.00 and 17.00. There was evidence of that call being delivered at 18.00. The bed time call should have been made between 19.30 and 20.30 and there was evidence of that call being delivered as late as 23.00. Other care files we viewed also showed a wide variance in call times. Some people told us that they did not have access to their care rota so that they would know who should be arriving and when. The registered provider had a system whereby rotas could be e-mailed to people. However, not all people were able to receive their rota in this way.

The registered provider did not ensure that care was delivered in a person centred way. This is a breach of Regulation 9 of the HSCA Regulations 2014.

Complaints were not consistently used as a measure to improve the service delivered to people. The service recorded all complaints in a complaints log and there was a complaints procedure that set out the process of how complainants should be responded to and a timescale given. People who made complaints had received a written response within the timescale set out in the registered provider's policy. We read through eight complaints and found that there was a recurrent theme in some of the complaints around the perceived attitude of some members of the management team. We reviewed the responses to the complaints and found that this issue had not been addressed. In addition we saw responses to complaints that were not person centred or receptive to the concerns raised meaning that opportunities for improving the quality of service experienced by people and their relatives were missed. For example one person who complained that an early care call disrupted a visit the person was having from friends received a response that explained why this may happen but also put the focus back on the complainant by suggesting, "Maybe you could also explain to carers about changes in times, and how it disrupts your routine as well, as it seems so easy to blame "the office"." Another relative had complained that their loved one did not have a rota of who was coming to care for them and was told, "X was provided with a paper copy of the rota on a Friday, however when it changed they would be quite rude on the phone." The reply went on to explain that rotas are emailed to carers so there is no need for carers to come to the office to pick up a paper copy of the rota. The relative was then advised, "Other clients phone our office for a summary of who is coming and what time, which X could have done, but didn't. We also have relatives collect rotas or we email them to relatives and they pass it on to the person being cared for." One relative told us, ""I spoke to the manager about getting X out of bed into the chair, as advised by his consultant and the district nurse who said the bed is not the same thing. The manager would not listen to me, even though I told her what the consultant and DN had said. It has never been resolved. The manager will not listen to my point of view, and said to me that there are people who need more urgent calls than my husband."

We recommend that the registered provider reviews its procedure for responding to complaints.

Requires Improvement

Is the service well-led?

Our findings

People and staff members spoke positively about the acting manager, the management team and the registered provider. One staff told us, "The [acting] manager is very approachable." Another staff member commented, "The manager and office manager are very approachable: always easy to get hold off." A third staff member told us, "I definitely feel able to approach the manager. I also get regular supervision and we have regular team meetings." One person commented, "A few months ago I thought they were closing down, and I panicked and the manager came over to reassure me because they know what a bad experience I had before [with a previous agency]. I would give them a gold star."

The provider did not have effective systems in place to monitor the quality of care and support that people received. The registered provider used quality management system that is used globally, known as BS EN 9001. The quality monitoring system had been audited by an external professional and had been marked as pass subject to rectification. These rectifications had been made. There had been some improvements identified by the system such as, "assessments carried out before start of service now include thorough front page for care worker of what is expected." However, there was a schedule for which areas of the service should be reviewed each month. Monthly reports, following this schedule, were completed up to August 2016 but none had been completed between August and December 2016. The quality monitoring system had not identified shortfalls such as medicines not being recorded effectively, that risk assessments had not identified risks and hazards not being mitigated where they had been identified and that care plans lacked sufficient details to ensure they were person centred. This meant that the quality monitoring system used by the registered provider had not been effective.
The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

There was an on call system in place for out of hours emergencies. The on call manager would write a report for the acting manager detailing any issues, such as sickness, and the acting manager would look at people's sickness records and look for patterns. The registered provider also used spot checks to ensure that tasks such as house work were being completed to a high standard. Spot checks were structured so that a senior carer was given specific things to check when overseeing the work of a new carer. The acting manager told us, "We have observation forms that highlight tasks that should be completed to the standard expected within the company. Anything falling below that is brought to supervision and addressed shortly afterwards. The observations are task related and feedback from the client is also noted. These observations are always conducted by a senior co-ordinator who has relevant qualifications and team leading skills and understands the policies and procedures of the company." The registered provider had also ensured that competency checks were in place for staff members for medicines administration and moving and handling training.
The registered manager was no longer in day to day control of the business. We were told by the acting manager that the registered manager intended to de-register but to remain the nominated individual for the organisation. The acting manager had been in day to day charge of the organisation for more than one year. Subsequent to our inspection the acting manager informed us that they were in the process of applying to be the registered manager for the organisation with the CQC.

The culture of the organisation was supportive to staff members. The acting manager told us, "It's a very open house and communication is top of that." One carer told us, "Communication is what they're good at. They are brilliant at it. They do genuinely care." The acting manager told us, "I'm good at supporting people as well. Everyone knows what their job is and we have an open office and rely on staff. Staff know if they have a personal problem they can come in just for a chat." During our inspection we saw that staff would come to the office for a catch up and the atmosphere was open and friendly. The acting manager gave examples of how they had been able to help staff with personal problems, for example by changing shifts and how wages were paid. They told us, "We've had carers stay for 14 years, others stay for eight or nine years and then if they leave for maternity they will come back because we respect the staff and if people need certain hours or money we give them the hours they need."

The acting manager had a clear vision for the organisation. The acting manager told us, "The company will go with what demand is and as complexities come in to the community we will seek expertise to cascade information down to carers and give them the information they need. As the company gets bigger we will get more care co-ordinators so that the paperwork is kept up to date. We look at the qualities that care staff have and give people the opportunity to progress: that way staff stay." The acting manager had recognised the challenges facing the organisation in the future
The acting manager spoke about the likely increase in complex needs people in the community and how the role of the carer may well change to closer to a healthcare assistant in hospitals, which would put pressures on training. The acting manager told us that they were already working closely with different professionals and as the role of carer changes they will work closely with nursing teams to deliver training and support to complex people in their homes.

The registered provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered provider confirmed that no incidents had met the threshold for Duty of Candour.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that care was delivered in a person centred way.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not ensure that consent was sought in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure that ensure that people were kept safe from risks or avoidable harm. The registered provider did not ensure that medicines were being managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not kept complete and contemporaneous records for each person. The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service.

Regulated activity	Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered provider did not ensure that ensure that safe recruitment procedures were followed.