One to One Support Services Limited

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Inspection report

Devonshire Court, 25A Devonshire Terrace
Heath Road, Holmewood
Chesterfield
Derbyshire
S42 5RF

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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?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 25 September and 2 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk with staff and review records. Telephone calls to people were completed on 26, 27 and 28 September 2017. Telephone calls to more staff were made on 6 October 2017. Telephone calls to other health and social care professionals were made on 27 September and 2 October 2017.

The service provides personal care and support to people who live in their homes in and around the Chesterfield area of Derbyshire and parts of Sheffield. The service cares for older people as well as people with sensory or physical disabilities, mental health needs and people with learning disabilities or people with an autistic spectrum disorder.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the provider. At the time of this inspection 121 people received support with their personal care needs.

The service is required to have a registered manager. 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. At the time of our inspection there was a registered manager in post.

Some areas of the service did not have sufficient staff and some people experienced late or missed calls. Care plans did not always reflect full details of the medicines people received and medicines administration record (MAR) charts had not always been completed.

Policies were in place so people's care could be provided in line with the Mental Capacity Act 2005 (MCA) if they lacked the capacity to consent to their care; however records of mental capacity assessments and of best interest decision making had not been made by the service. Not all staff fully understood the MCA.

Some people felt care did not always promote their independence, choice and control. Some people felt

care was rushed and care staff were not consistently introduced to them before their care began.

Records of people's care and treatment, for example MCA records and medicines administration record (MAR charts), were not always recorded where needed. Records were not always accurate and completed contemporaneously. Statutory notifications had not been submitted to the CQC when required. Systems and processes designed to check on the quality and safety of services were not always effective.

Other risks were assessed and actions to reduce risks were identified; for example what steps staff should take to ensure any equipment used was safe. People felt safe and staff knew what steps to take to should people be at risk from harm or abuse. Recruitment procedures were followed to ensure staff were checked to ensure they were suitable to work at the service.

Staff received training in areas relevant to people's needs and training dates were booked for staff identified as requiring further training or refresher training. Staff felt supported by their managers and had the opportunity of supervision meetings with managers.

People were supported to have good health and nutrition and staff knew people's food and drink preferences.

People's privacy and dignity was respected by staff who took steps to ensure this was promoted during care. People were involved in developing their care plans and knew they could discuss their care with staff.

The views of people and their preferences were known and respected. People had opportunities to raise issues regarding their care through feedback and knew how to complain should that be needed. People's views were sought when the registered manager evaluated the quality of the service.

A registered manager was in place and they had taken steps to develop the service. Staff were motivated in their roles.

At this inspection we found two regulated activity breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we asked the provider to take at the back of the full version of this 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.

Sufficient staff were not deployed throughout all areas of the service. Care plans did not always reflect full details of the medicines people received and medicines administration record (MAR) charts had not always been completed.

Other risks were assessed and actions to reduce risks were identified. People felt safe and staff knew what steps to take to should people be at risk from harm or abuse. Recruitment procedures were followed to ensure staff were checked to ensure they were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff checked people consented to their care. Policies were in place so people's care could be provided in line with the Mental Capacity Act 2005 (MCA) if they lacked the mental capacity to consent to their care, however records of capacity assessments and of best interest decision making had not been made by the service. Not all staff fully understood the MCA.

Staff received training in areas relevant to people's needs. Staff felt supported by their managers. People were supported to have good health and nutrition.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care did not always promote people's independence, choice and control. Some people felt care was rushed and care staff were not consistently introduced to people before their care began.

People's privacy and dignity was respected by staff. People were involved in developing their care plans.

Is the service responsive?

Good

The service was responsive.

The views of people and their preferences were known and respected. People had opportunities to raise feedback and knew how to complain should that be needed. People received personalised care and were involved in on-going discussions with staff over what support they needed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records of people's care and treatment were not always in place where needed. Nor were records always accurate and completed contemporaneously. Statutory notification had not been submitted to the CQC when required. Systems and processes designed to check on the quality and safety of services were not always effective.

A registered manager was in place and they had taken steps to develop the service. Staff were motivated in their roles. People's views were sought when the registered manager evaluated the quality of the service.

One to One Support Services

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 between 25 September 2017 and 6 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk to staff and review records. The inspection team included 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 looked at all of the key information we held about the service, this included information of concern over late or missed calls, medicines management and care records. We also used the results of a questionnaire type survey we had sent to people who used the service, their relatives, staff and community professionals who had experience of working with the service.

We had also asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the provider. We also reviewed any statutory notifications. Notifications are changes, events or incidents that providers must tell us about; no notifications had been submitted.

We spoke with two local authority commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical

commissioning group. We also checked what information Healthwatch Derbyshire had received on the service. Healthwatch Derbyshire is an independent organisation that represents people using health and social care services.

In addition, during our inspection we spoke with twelve people who used the service and nine relatives of people who used the service on the telephone. We also spoke with the registered manager, four support workers, three senior support workers and one manager who managed a local team of care staff.

We looked at six people's care plans and reviewed other records relating to the care people received and how the agency was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Requires Improvement

Our findings

Some people who received care in specific geographical areas of the older person's service told us they experienced late and missed calls. One relative told us their family member had sat in their nightclothes until midday recently as no care staff arrived as expected. On this occasion they had not been able to contact the office for help as it was at a weekend and the on-call phone voicemail was full. They said they had asked care staff, "If you can't deliver a call please telephone; next day no call, no phone call; I despair, really I despair." They added they felt the care appointments were poorly organised because on another occasion, two care staff arrived on the same day, but at different times for the same call. They told us, "Either they are incredibly stretched, or they are unprofessional." Another person told us, "We're given a time slot of between 9:00am to 10:30am for the care staff to arrive and to help me with my shower. They are usually here within that time, but more than a few times lately, they have been really late; not getting here until almost 11:30am and 12:00noon. My [relative] and I go [out] to have our dinner; on at least two occasions we had to send [the care staff] away because otherwise we wouldn't have got a cooked dinner that day if I had just stayed in and had my shower." A further person told us they had also experienced missed calls the week prior to our inspection.

The results from our survey showed over a quarter of the 19 people who responded told us their care staff did not arrive on time, and they did not receive care from familiar and consistent care staff. One person reported they required their care to be on time because of their health condition; they reported they had not been receiving their care on time. A relative commented their family member was, "Not washed some days from carers not spending all time that is needed due to their schedules." Nearly half of the 19 staff who responded had found the way their care appointment had been organised meant they were unable to arrive on time or stay for the agreed length of time.

Some staff we spoke with told us there were staff shortages in some areas and although they tried to make sure all care appointments were covered, this had not always been possible. One staff member told us, "We try to get there on time; sometimes [people] have gone without a call." Another staff member told us about the 'buddy' system used to ensure staff cover was arranged to cover staff absences was not followed by all staff. They said, "There's been late calls, and on occasion missed calls; if staff are ringing in sick they've not used the buddy system."

Records of management meetings between July and August reflected there had been staffing issues, including sickness and too many staff off on annual leave. Records also recorded senior support workers had also been off at the same time and this had left no cover should there have been an emergency

situation. Records also showed where mis-understandings between staff who arranged call appointments and a person resulted in care staff not attending on the days the person expected.

We discussed the concerns raised from people in specific geographical areas of the older person's service with the registered manager. The registered manager told us they were aware people who lived in specific geographical areas had received missed and late calls; the last known incident of a missed or late call investigated by the registered manager had been approximately three weeks prior to our inspection. The registered manager told us they were in the process of recruiting additional staff to cover this geographical area and told us they did not consider staff shortages to be a long term issue. The registered manager told us they had experienced a difficult handover from the previous agency that operated in this geographical area. This had included a reliance on agency staff; staff not following the provider's systems and processes, including the failure to attend arranged calls and report missed calls to management.

There was not sufficient numbers of competent, skilled and experienced staff deployed within specific geographical areas of the older person's service to ensure people received safe care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These experiences were in contrast to people we spoke with who received care to support their sensory, mental health, learning disability or autistic spectrum needs, or were in different geographical areas. One person told us, "I've never had a problem with my care staff. I only have three different care staff who come all the time; if they are running late because they've got stuck in traffic, they will always just give me a quick call because they know I get anxious if they're not here on time. Most of the time however, they are here on time and they never go until a few minutes after the time they are supposed to have finished." In addition, a relative told us, "[Name of person] needs two care staff all the time; they always arrive together."

However, one relative commented, "The only thing that concerns me at present, is the fact that there are some highly skilled staff leaving at the minute; I told them that I'm concerned because they don't appear to have a plan in place to replace these care staff. You can't just get sign language qualified care staff overnight and I'm worried about the continuity of care for my [relative] in the meantime."

People told us how care staff helped them with their medicines. One person said, "My care staff pass me my tablets out of the box and give them to me with a drink. Once they have seen me take them they write it in my notes. Because I never quite know what time my care staff are going to arrive, it can be varying times from one day to the next that I get my tablets, but thankfully on the instructions it doesn't say that they are time specific." A relative we spoke with told us they did not feel confident one member of care staff had understood where to apply prescribed cream to their family member. They told us the cream had to be applied to a specific area and instead care staff had, "Just slapped it all over." They told us staff did not make any record of the cream they had applied.

How staff provided care to people in relation to their medicines was not always clearly identified in a care plan. Care plans and medicines administration record (MAR) charts were not always in place when staff assisted people with medicines. One relative had told us care staff applied prescribed cream to their family member and told us staff did not record this. Daily notes for another person showed staff assisted them with creams for their legs as well as a gel for their shoulders. There was no care plan in place to record what the cream and gel were, or where they were to be applied. We discussed this with the registered manager who told us one cream was a moisturiser type cream and the other was a non-prescribed pain relief gel obtained from a pharmacist. The registered manager told us they would introduce a MAR chart for the pain relief gel

with immediate effect. For another person, staff applied prescribed creams, however there was no body map in place to ensure staff were consistent in where and how they applied the creams. The registered manager told us they had introduced a body map to show where the person's creams were needed. Staff we spoke with told us they had been trained in medicines management and knew to record any administration of medicine on a medicines administration record (MAR) chart; however these had not always been in place for staff to use.

We saw staff had recorded when they had administered medicines through a percutaneous endoscopic gastrostomy (PEG) tube. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medicines can be given without swallowing. Daily notes showed staff had also regularly prepared medicines ready for family members to administer the medicine, however this preparation was not recorded on the MAR chart. We discussed this with the registered manager who told us the specialist procedure was due to be signed by relevant professionals shortly after our inspection and that MAR charts would be amended to record when staff had prepared medicines only, as well as when they prepared and administered medicines.

Staff we spoke with told us other risks were assessed and managed well. One person told us, "[A manager] came and looked at [my family member's] hospital bed, hoist and shower chair before the staff started looking after them; [the manager] told us they wanted to ensure that it was all safe and in good order." One staff member told us any environmental risks were assessed; such as any falls risks from loose floor coverings, as well as any specific risks to people's health, for example if people required soft texture foods due to swallowing difficulties. Records we saw confirmed these were in place, for example, we saw risk assessments and guidance for staff to follow to provide care if a person had an epileptic seizure.

People told us staff took actions to reduce and manage any risks. For example, one person told us, "There is never any problem with staffs' hygiene skills; I never have to remind them." Another person commented, "My regular carers who have been coming to me for a long time always ensure thy have their gloves and aprons and they change them appropriately." However they added, "I've noticed of late though, that some of the other carers who I haven't seen for very long, need more prompting to either put them on in the first place or change them between tasks." Staff told us they had sufficient supplies of gloves and aprons to help prevent and control infections. Staff also told us they would report any accident, incident or a near miss and records we saw confirmed incidents were reported. These were reviewed by the registered manager to ensure all steps to reduce any further risks were identified. Records also showed staff took appropriate action in emergencies, for example, when staff found a person had fallen, they called an ambulance. Actions were taken reduce and manage risks.

The results from our survey showed people and relatives felt safe from abuse or harm from the care staff that worked at one to one support services. Staff we spoke with told us how they would recognise any suspected harm or abuse of a person. They told us how they would report any concerns and were knowledgeable of the provider's whistle blowing policies. Whistle blowing is a procedure under law that protects staff from being treated unfairly by their employer if they have raised genuine concerns about a person's care. Staff told us, and records confirmed they had received training in safeguarding adults.

We asked people whether they felt safe when staff cared for them. One person told us, "To be fair, I do. Thankfully, I only need fairly basic help which they manage alright. Some [staff] are better than others, but that's just down to their own competency and general attitude to the work." A relative told us, "I wouldn't trust [my family member] to anyone else's care but theirs. The staff can't do enough for them. Staff have gone over and above, particularly when we had [a family emergency] and staff stayed to ensure they had a familiar face whilst I had to concentrate on other things." People felt safe with the care staff provided.

We looked at how the provider recruited and managed staff. Staff told us and records confirmed, the registered manager had checked references and obtained information from the Disclosure and Barring Service (DBS) when recruiting staff. Records showed all the required pre-employment checks had been completed. Staff were recruited in line with the provider's policies designed to ensure the safety of people using services.

Requires Improvement

Our findings

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 so that they can 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. The service had policies in place that covered the MCA and making decisions in a person's best interests. We asked to see mental capacity assessments in place and records of decisions agreed to be in the person's best interests. For example, one person was restricted from accessing their medicines and their medicines were locked away. They also at times refused personal care, had refused to lock their house and had refused to read their care plan. We were also concerned this person's mobility was affected due to the condition of their feet and they had continued to refuse staffs' offers to help in this area. The registered manager told us that best interest decisions had been taken at meetings, usually held once a year with the person's consultant and social worker, however the records for these decisions had been retained by the health professionals and were not available at this inspection. The registered manager told us they would make mental capacity assessments and best interests decisions in a multi-disciplinary setting. Whilst this is in line with the MCA, it is the provider's responsibility, and in accordance with the provider's own 'advocacy and capacity policy' to assess and record clearly a person's mental capacity in relation to specific decisions.

In the absence of records of mental capacity assessments for the areas of care and decisions taken; including decisions taken on a day to day basis by staff, the provider could not demonstrate the care and the decisions they had taken were in the best interests of the person. We discussed this with the registered manager who told us they would review their current practices around recording capacity assessments and best interest decision making.

Most staff we spoke with had a clear understanding of the MCA; however one staff member told us relatives could provide consent on behalf of a person if they lacked the capacity to consent to their care or make a specific decision. This is not in line with the principles of the MCA.

People told us staff would ask for their consent before providing care. One person told us, "Care staff always ask me if I'm ready for my shower when they come in a morning, and if I'm not, then they usually do a bit of

tidying up or make my bed until I am ready. If I don't feel like having a shower, they will just help me with a wash instead." A relative told us, "Care staff will never start anything with [my family member] until they are ready." Staff we spoke with were clear on the importance on checking people consented to their care before this was provided and gave examples of how they would do this. Staff checked people gave consent for their care.

People and relatives told us they felt staff had the relevant skills and knowledge to care for them or their family member. For example, one person told us, "All [my family member's] care staff are trained in sign language. Without this skill, they wouldn't be able to communicate with them." However another person commented on the differences in skill levels between the more experienced and new carers. They said, "From my perspective, some of the new carers who have started more recently don't appear to have had the same level of training as some of the most experienced carers. It's things like basic cooking skills, cleaning skills and I have to say, some basic hygiene skills that appear to be lacking; it shouldn't be my place to remind carers to change their gloves between jobs as that is just basic hygiene, or should be."

Care staff told us they received training with the provider. One care staff member told us, "To be honest it's the best company I've worked for and they take pride in their training; the training is brilliant." They also added they had completed an induction period where they could familiarise themselves with the provider's policies and procedures. Another care staff member told us they worked alongside more experienced staff before they provided care on their own. They said they felt they had, "Enough skills and knowledge to support people."

The registered manager showed us records where staff had completed training or where future dates had been booked for training identified as required for the needs to the people they cared for. For example, some staff had completed British Sign Language (BSL) training to enable effective communication with BSL users, others had completed training specifically for epilepsy awareness when people they cared for had epilepsy needs. Where care staff had joined the company, the provider had completed a skills and training audit to identify any training required. Although not all new staff had as yet completed the all the training identified as required by the provider, steps had been taken to arrange this. One new staff member told us, "I've been booked onto training all the way through to [next year]." In addition, further training to develop staff skills had been identified and planned for, for example, the registered manager told us for staff new to management roles, further training in management skills had been booked. Staff were supported to have the skills and knowledge required to provide care for people.

Staff told us they received support from the registered manager and other office staff when this was needed. One staff member told us, "If anything's wrong, you can phone up and get support." Another staff member told us they had regular meetings where any updates about the company were shared; in addition they also told us they had specific meetings focussed around the needs of the people they supported. Records confirmed staff attended these meetings and received updates and had opportunities to discuss how to provide effective care to people by sharing their ideas in meetings.

Staff also told us they had supervision. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. However, one care staff member reported since they joined the company in March, supervisions had only just been arranged. Records we saw showed staff had supervision meetings arranged. In addition staff told us senior staff observed their practice and provided feedback on what they had done well and any areas for improvement. We spoke with a senior care staff member with responsibility for checking staff competency; they told us they checked staff competency in such areas as medicines management, assisting people to move, records as well as how well staff promoted a person's dignity. These actions help to ensure staff are supported and

follow good practice in their job role.

People who received care with their meals and drinks told us they had sufficient to eat and drink and that their preferences were met. One person told us, "I have a microwave meal made for me at lunchtime and then care staff will usually make me a sandwich and they put it in the fridge so that I can get it for myself at teatime. They usually have to remind me what I've got in the fridge and freezer because I forget these days. They always make sure my meal is piping hot before I have it on a tray on my lap." A relative told us, "They will cook [my family member] a meal while I am out and always make sure it's something they like. They always tidy the kitchen up after themselves as well." People also commented on how they were helped to take sufficient fluids as well. One person told us, "Care staff are very good and always make me a hot drink when they first come and another one for me before they leave, which they put on my little table for me, with some biscuits." A relative commented, "Care staff are very good and encourage [my family member] to drink while they are out with them as well."

Staff we spoke with were knowledgeable on any special dietary requirements people had; for example, on care staff member told us about how the person they cared for required a modified texture diet. Another staff member told us the favourite food and how one person they cared for liked their drink preparing in a specific way. Records we saw showed people's dietary needs were identified and any preferences they had were known. Daily records recorded where staff had offered people choices and provided food and drink of their preference. People received care so that they had sufficient food and drink that met their preferences and needs.

People were supported effectively where other healthcare services were involved in their care. One person told us, "My care staff take me to any [health] appointments. If there are any changes to my tablets it all gets written up straightaway." Another person told us, "Care staff have called my [relative] before now when I've been showing signs of ill health, so [my relative] can follow up with me and call the GP if necessary." One relative told us, "The care staff are all very good, because they've been with [my family member] for a long time they are able to spot when she is becoming unwell. Care staff will always let me know as soon as they notice anything, so that we can get the doctor on board and visiting before they become more seriously ill." Records identified what other healthcare professionals were involved in meeting people's associated health needs. For example, contact details for social workers and consultants. The service helped people to maintain good health as they understood how to involve other healthcare services to ensure people's healthcare was appropriate.

Our findings

Some people who received care in the older person's service explained how time pressures and continuity of staff affected how caring they found the service to be. For example, one person told us, "On the whole care staff are [kind and friendly] but you get the feeling that they are all rushing around so much to fit everyone in, that sometimes they just need to concentrate on getting the job done and being out of here as quickly as possible. I don't blame them; I blame the management for asking them to do too much." Another person said, "I have to say that usually I will be introduced to a new carer first and they will shadow one of the other carers before coming on their own; but the last couple of months have seen lots of carers leave and I have, once or twice, opened the door to someone totally new." Another person commented, "The carers I see regularly know me by now and also know how I like things to be done. It's the carers who only come once every two or three weeks that make it more difficult for me, because I end up having to explain every time how I like things to be done; it's never a problem, but it would be easier if I just had three or four carers who could come most of the time." The results of our survey also showed people and families were not always introduced to their care staff before they provided care and support.

One person told us how this had also led to staff not always promoting their independence. They told us, "I do try and wash as much of me as I can before my carer does the rest of me that I can't reach. Just a few carers rush in though and just try and do it all themselves before I have a chance to say that I can actually manage. That's what happens when they don't come very often, as they've forgotten just what I can and can't do for myself." Not all people received care that supported their independence.

This was in contrast to the experiences of people who received care in the other areas to support their sensory, physical, mental health, learning disability or autistic spectrum needs, or were in different geographical areas. Their comments included, "Because I need carers with certain skills, I'm always introduced to new carers first and they always shadow an experienced carer before coming on their own," and, "I get very anxious and am not comfortable going out on my own, but my carers give me the confidence that if anything happens, they are there to support me and they never mind going anywhere with me." A relative also told us, "The care staff take [my family member] out and about, wherever they fancy going and they look forward to seeing the care staff."

They also gave examples of how staff had promoted their privacy, dignity and independence. One person told us, "They do actually encourage me to do as much for myself as I can and I know that it can take longer than if they were to take over and do it themselves. I really respect the fact that they give me time and space to try myself."

Staff we spoke with told us the steps they took to ensure people's privacy and dignity was respected. For example one staff member told us when they assisted a person to use the toilet, "I will explain what we are doing and pop a towel over their lap and shut the door." Some people received care that promoted their independence, dignity and privacy.

People across the whole service told us about the things care staff did to help them feel cared for. For example, a person told us, "The care staff always make sure the shower is nice and warm for me before I get in. Because I can fall easily, without them being here, I just wouldn't be able to shower anymore; and I do so love my shower."

Staff spoke with warmth and affection for the people they cared for. One staff member spoke about a person they supported; they said, "She's lovely." Another care staff member told us how being a consistent member of a person's staff team helped them build us relationships. They said, "They are your clients, you get to know their routine, what they like and don't like, and from day one we hit it off." People received care from staff who enjoyed providing care.

People also told us care staff respected their homes. For example, one person told us, "Care staff help me with all my housework and I've never had anything broken at all. They look after my things like they would look after their own." Another person told us, "Care staff have to use the key safe to let themselves in; they always make sure the door is secure and the key away safely before they leave."

People gave us examples of when they felt care staff listened to them and how this helped them feel involved in their care. One person told us, "We always see or speak with [name of care staff]; they are really flexible and never mind changing hours to fit in with things we have going on." People we spoke with knew about their care plans and felt staff involved them in their care.

Good

Our findings

People told us they knew how to make complaints or compliments. One person told us, "Yes, we were given a complaints leaflet when we first started with them." A relative said, "I think it was mentioned when we met one of the managers."

Policies and procedures were in place to manage complaints should any be made. One relative told us, "I've only ever had an issue with one care staff who [family member] didn't get on with and when I told the agency about it, they didn't send that care staff again. I was very happy with how they handled it, so I don't see why they wouldn't be the same with any other problem that we might have." Another person told us they felt they had not received a response to their concerns from a local manager, however we saw their concerns had, at a later date been addressed by the registered manager. Records showed complaints and concerns had been received and responded to. We also saw a selection of thank you cards and compliments from people and their families who used the service. People were able to make complaints and feedback and received a response.

People contributed to reviews of their care. One person told us, "When we have a review meeting with [the manager] we look at it and see if anything needs changing in it." Another person told us, "I always talk with [name of care staff] as she has done my reviews and knows me well. I'm sure she'd help me with anything I needed sorting out." During our inspection we saw the service responded to changes in a person's needs. The person had become unwell and as a result extra staff were arranged to ensure the person could be cared for throughout the day. Records confirmed people's care plans had been reviewed with them. People had opportunities to contribute to their care plan to help ensure their care was responsive to their needs and the service was able to adapt and change quickly when needed to meet people's changing needs.

People told us how care staff provided care to meet their known preferences. For example, one relative told us, "My [family member's] one main interest is how films are made. They have a member of staff that comes and spends time with them and they could chat all day about films; I leave them to it." Another person told us, "On the whole, the care staff are not bad. The ones who come more regularly know me better and will always put me out some biscuits with my cup of tea without me asking them."

Records showed people's life histories had been discussed with them, and summaries of these discussions had been included in care plans. Staff we spoke with could tell us about the interests and hobbies of the people they supported and told us this helped them form relationships with people. For example, one staff member told us how they took into consideration a person's religious observations. They told us they knew

when the person would be fasting and required food prepared in line with their religious beliefs. They told us they accepted an invitation to be involved with celebrating a special event in the person's religious calendar.

Requires Improvement

Our findings

The registered manager had not ensured records of people's care and treatment were always in place, accurate and completed contemporaneously. For example, the registered manager had not recorded mental capacity assessments and best interests' decisions in line with their own policy. In addition, they had not retained records of decisions taken in relation to the care and treatment provided to people. This meant records of people's care and treatment were not always accurate and complete.

Staff had not always been able to follow the provider's policy and procedure for recording the administration of medicines. This was because MAR charts had not always been in place when staff had applied creams; in addition one staff member told us they had experienced problems with MAR charts. They explained new MAR charts had not always been in place at the start of a new medicines cycle. This meant staff had been unable to follow all the steps in the provider's medicines policy, designed to ensure the safe management and administration of medicines as no MAR charts had been in place.

Systems and processes designed to assess, monitor and improve the quality and safety of services provided and mitigate risks relating to health and safety of services provided were not always effective. This was because MAR charts were subject to checks at the office to identify any errors or missed signatures that would require further investigation. However, two staff told us they would ensure any gaps on the MAR chart were completed before returning them to the office. Staff told us they did this so the staff who had not signed would not, "Get into trouble." This meant that audits of MAR charts were not always effective as any omissions or errors on MAR charts had been rectified before they reached the office for auditing.

Systems and processes to assess, monitor and improve quality and reduce risks to people had not effectively identified missing MAR charts. The registered manager told us quality audits on people's daily notes and any subsequent records such as MAR charts took place at the end of each month. We looked at the daily notes for this person's care in July and these showed staff had recorded they had administered medicines on a daily basis; one of these medicines was a pain relief gel, however no MAR chart had been completed. The quality audit for July 2017, and the previous three months was blank and had not been completed. This meant the lack of a MAR chart, and a care plan for the medicines staff administered had not been identified as missing as no audits had been completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

During our inspection we became aware of where allegations of abuse involving people who used the service had been made and also of an incident where the police had been involved. The registered manager is required to notify the CQC about incidents such as these; they had failed to do so.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Other checks on the quality and safety of services were in place. For example, we saw staff were observed in their job role to ensure they were competent. We spoke with staff who observed staff for their competence; they told us they checked staff were following the correct policies and procedures and used equipment safely. Records we saw confirmed this. Other meetings were held regularly and checked on further areas of governance. For example, checks on whether staff had completed the necessary training required for their role, that care plans were reviewed and updated and people had been asked for feedback.

The registered manager had taken steps to support the development of quality care. For example, they had achieved one dignity in care award, and were continuing to work to develop this further. The registered manager had also achieved awards in business management and staff training and was keen to use her knowledge of business in the further development of One to One Support Services.

However, one relative who had been affected by late and missed calls told us, "One to One need to understand the bits they are not doing well; it's really the management that need to understand that." They added, "[The registered manager] is only a name on a piece of paper." Another person told us they knew the local manager but not the registered manager and a third person told us, "I don't think I know who's in charge; I only ever see the carers or talk to someone in the office." Not all people knew the registered manager or felt the registered manager had plans in place to improve the staff shortages affecting one area of the service.

Staff told us they felt the registered manager and other managers were approachable. One staff member told us, "There's always someone to talk to." Staff we spoke with were motivated in their job role and enjoyed working for the service; although some staff told us they felt tired from covering staff shortages in one area. One staff member told us, "They are very flexible and good with staff." Another member of staff described how they attended an 'introduction to working in care' training course run by One to One Services training service. They told us they now had a job with One to One and said, "I'm absolutely loving it." Staff also commented on the support from all members of the office team. One person said, "Everybody is so helpful and so hands on; everyone is willing to give advice." The registered manager was supported by staff that were motivated and enjoyed their work.

People had been asked their views regularly on the service with a written questionnaire. However, not all people told us they knew what actions were taken as a result of their feedback. One person told us, I've filled in one or two surveys, but I can't remember hearing about them afterwards." Another person said, "Yes, I'm sure I've filled in some questionnaire things in, but I don't think I've ever been told what the responses were from other people." Records showed people's responses had been analysed for any areas where improvements could be made. When people had identified and issue we saw the registered manager had recorded the steps staff should take to find out more information to resolve the issue. People had opportunities to share their views on the quality of the service.

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 Statutory notification had not been submitted when required. 18(1)(2)(e)(f)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided had not always been maintained. 17(1)(2)(a)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not always been deployed to provide care to people. 18(1)