Excel Care (UK) 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 13 April 2018 and was announced. Excel Care (UK) Ltd (Excel Care) are registered to provide the regulated activity of personal care. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. There were 12 people using this service at the time of our inspection.

Not everyone using Excel Care receives the regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the last comprehensive inspection in July 2017, we judged that improvements were required in delivering a safe, responsive and well-led service.

We found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not carried out all required recruitment checks to make sure staff were suitable to work with people who used the service. The provider had not ensured people's risk assessments contained specific guidance about what actions needed to be taken to reduce or remove the risk. The provider had not established an effective system that enabled them to ensure compliance with the requirements of the fundamental standards.

We took enforcement after the last inspection to cancel the registered manager's registration, and this concluded in December 2017.

The service did not have a registered manager in place at the time of the inspection. 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 this inspection the provider was in the process of registering the service manager to become the registered manager.

At this inspection we found there had been improvements, which were sufficient for the service to be rated

as requires improvement overall and good in caring and responsive with no inadequate domains. This meant the service could come out of special measures. However, we found further improvements were required to ensure the providers auditing systems evidenced how they were managing late visits and the auditing of Medication Administration Records (MARs).

Improvements had been made to ensure that most people were visited by the same staff so they could build trusting relationships with them. The staff that visited people were kind, caring and compassionate. They treated people with dignity and respect and tried to help them be as independent as they could.

People told us they received consistent carers that attended within thirty minutes either side of the allocated timeframes. People told us they had not experienced any missed visits. People were satisfied with the consistency of care and told us they had regular care staff supporting them.

We examined staff training records which demonstrated that training relevant to their job roles was provided. However, new staff were not supported through the care certificate or equivalent. This meant we could not be fully assured new staff had received a robust induction in health and social care. Staff had received regular supervision and an annual appraisal.

People received their medicines on time and in a safe way. However, we have made a recommendation the provider introduces an individual medicines risk assessment as part of people's pre-admission to the service in line with 'Managing medicines for adults receiving social care in the community' guidance.

People were kept safe by staff who had an understanding of their responsibilities with regards to protecting people from harm or possible abuse. There were sufficient numbers of staff employed at the service and staff had been recruited appropriately with pre-employment checks completed before staff commenced working at the service.

The provider had a clear understanding of the Mental Capacity Act 2005. They were knowledgeable about protecting legal rights of people who did not have the capacity to make decisions for themselves. The service acted in accordance with legal requirements to support people who may lack capacity to make their own decisions.

There was a complaints policy and procedure in place and we saw that complaints had been recorded and investigated with an outcome recorded.

Staff supervisions and appraisals had been completed in line with the provider's policy and procedures. Staff meetings had been held regularly to support staff and gain their feedback to improve the service.

People received a service that was based on their needs and wishes.. Care plans were personalised and contained detailed information about the support people needed.

There had not been any accidents, incidents or complaints. Policies and procedures were in place which would ensure any accidents, incidents or complaints would be effectively dealt with in a timely way.

Satisfaction surveys had been completed by people and their relatives and the majority gave positive feedback. However, we found these surveys had not been analysed to evidence any changes as a result of the feedback

There were quality monitoring systems in place; these included satisfaction surveys, spot checks and

internal audits. However further improvement was required to ensure people's medicines records were audited and analysed to ensure people received their medicines safely. Furthermore, the provider had not ensured late calls were analysed to improve the timings of scheduled calls. The provider acknowledged that this was an area which required further development and steps were in place to address this as a matter of priority.

This is the fourth consecutive inspection that the service has been rated Requires Improvement. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines management was safe, however further improvement was required to ensure people's level of support in respect to their medicines was accurately recorded.

People told us they felt safe with the service and that they generally received consistent care. However, some people felt staff did not arrive at the allocated time.

Staff understood how to recognise potential abuse, and were aware of how to report concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training and supervision to enable them to develop further skills and knowledge. However, the care certificate or equivalent was still not in place for new staff.

The provider and care staff were aware of and understood the principles of the Mental Capacity Act and this had been reinforced in staff meetings. There was a policy in place to guide practice.

Arrangements were in place to request support from health and social care services to help keep people well. External professionals' advice was sought when needed. Families were consulted and felt involved.

Is the service caring?

Good

The service was caring.

People were treated in a kind, caring and compassionate way.

Staff demonstrated they had a good knowledge of people's needs and routines.

Staff had developed positive relationships with the people they supported and knew them well.

Is the service responsive?

Good

The service was responsive.

People's care was provided in accordance with their assessed needs and wishes.

People's nutritional needs were met.

A complaints procedure was in place and people knew how to make a complaint and were confident it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems and processes that were in place to monitor and improve the quality and safety of the service. However, further improvements were required to ensure medicine records were accurately audited on a regular basis and, analyses of late visits were required.

Regular staff meetings were held and minutes indicated that care staff had the opportunity to discuss matters relating to their work with managers and colleagues.

The registered manager had informed CQC about events that had occurred.

Excel Care (UK) Ltd

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 9 and 13 April 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office on the day of the inspection to help respond to our questions and to provide us with evidence. The inspection was carried out by one inspector.

Before conducting our site visit, we asked the provider to complete 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 looked at other information we held about the service including notifications. A notification is information about important events including safeguarding and serious injuries to people using the service, which the service is required to send us by law.

Prior to carrying out our inspection, we contacted Manchester City Council contracts and commissioning and Healthwatch Manchester to find out what information they held about this service. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services. Healthwatch did not have any information about this service. In response to our request for feedback, the local authority told us they did not have any information about the service. This was because monitoring visits were not carried out as they did not have a contract with this provider and purchased care packages on an 'as required' basis (referred to as a 'spot purchase').

With their consent, we spoke with two people on the telephone and we visited three people in their homes and spoke to two family members. We also spoke with the provider, the service manager, administrator and

two care staff.

We reviewed care records for four people who used the service to ensure they were reflective of people's current needs and three staff files which contained information about recruitment, induction, training and supervisions. We also looked at further records relating to the management of the service, including quality control systems to establish if the service had robust quality assurance processes in place.

Requires Improvement

Our findings

At the previous inspection in July 2017 we found that the care people received was not always safe. People were not consistently supported in a safe manner. Recruitment was not always robust and there were inconsistencies in the process, such as completion of pre-employment checks. People did not always receive their support at the expected times.

At this inspection people told us there had been some improvements. One person told us, "I think it is a good service, many of the old staff have now left, which I prefer." Another person told us, "I do feel safe with my care staff, they haven't let me down and are always eager to please." A relative told us, "I do feel my [relative] is safe, they [staff] do call them now if they are running late which is imperative otherwise they don't know what time to expect them and this has improved."

At our last inspection in July 2017 we found the provider was in breach of Regulation 19. The recruitment process did not provide robust assurances that adequate pre-employment checks had been completed and suitable staff employed. At this inspection we found the necessary improvements had been made.

We viewed three recently recruited staff files, which confirmed that all the necessary checks had been completed before staff had commenced work at the service. This helped to reduce the risk of unsuitable staff being employed. We saw that all staff had completed an application form, which included their employment history. Recruitment checks included obtaining references, confirming identification and checking people with the Disclosure and Barring Service (DBS). A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. Staff completed an induction process which included completion of all core training and assessments of competency.

At our last inspection in July 2017 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people's risk assessments did not contained specific guidance about what actions needed to be taken to reduce or remove the risk. At this inspection we found the necessary improvements had been made.

People had risk assessments in place and where potential risks to people's health, or safety had been identified. These were assessed and where possible actions were put in place to reduce or mitigate the risks and were kept under regular review to take account of people's changing needs. The assessments and reviews included areas such as moving and handling and environmental risks which may be harmful to

people's safety. Staff were able to describe how they kept people safe by checking their risk assessments and in particular when there were any changes to people's ability, they reported to management team to review. The provider recently recruited the services of an occupational therapist who worked at the service when requested by the provider. The occupational therapist completed several risk assessments including moving and handling to ensure people's risk assessments were current and included measures to reduce or prevent potential risks to individuals.

Equipment was noted in people's records so that if care workers were using equipment they could be confident safety checks had taken place by the company providing it. Care workers undertook training in health and safety topics including first aid and knew the action to take if someone was unwell or had an accident, including contacting the emergency services.

Risks were considered if a care worker needed the presence of a colleague to help minimise any issues with their safety. This was important if they were visiting an area deemed to be poorly lit, where there was limited parking or an area that was not assessed to be safe. We saw that for one person this arrangement was required and noted on the main part of the electronic care planning system that the care worker would read on their phones.

We found medicines were managed safely, although improvements were required to ensure people had been appropriately assessed to determine the level of support they required with their medicines. Four people who were using the service needed help with their medicines. Records documented what type of support people required to ensure they took their medicines as prescribed. We found two people only required their medicines to be prompted by care staff. However, we found staff were completing Medication Administration Records (MAR) for these people and providing full administration support. This meant the care staff were preparing the medicines from the dosette box and administering them to the person. Therefore, the records documenting that the medicines were to be prompted was inaccurate. We found the provider had not considered completing a medicines risk assessment to ensure the correct level of support people required was accurately recorded. During the inspection the service manager updated the care plans for the two people this concerned, to ensure the medicines records clearly recorded staff needed to administer and not prompt. We viewed the MAR for both people which indicated they had received their medicines as prescribed.

Care staff we spoke with confirmed they administered people's medication, if required, and that they had received the appropriate training. We saw evidence of this in their training records. We noted the service used an electronic care management system called PASSsystem to record people's medicines, the dosage and medicines administered. The service also recently introduced an additional safeguard with the introduction of a paper version of the MAR which was stored in people's homes. This meant care staff were now responsible for completing both the electronic care system and paper record MAR. The provider accepted a paper version of the MAR was required as a contingency in case the electronic care system software malfunctioned.

We recommend the provider introduces an individual medicines risk assessment as part of people's pre-admission to the service in line with 'Managing medicines for adults receiving social care in the community' guidance.

The provider commented that the electronic care system with the person's permission could be accessed by the person's family members and health care professionals, for example, GPs or paramedics. They told us 30 minutes access to the customer's care records could be achieved by downloading the electronic care systems app to a smartphone, registering as a user and then scanning the barcode on the front of the care

record. These instructions were on the cover of each person's care records.

We asked people and their relatives if they had experienced missed visits. We were informed by people and the provider there had not missed any visits since our last inspection. However most people we spoke with identified that care staff were sometimes late for their visits. At the last inspection in July 2017 we also identified this was the case, but people felt this was improving. While timekeeping was raised, people and their relatives confirmed the majority of staff always phoned to inform them they were running late.

We found the provider did not use the electronic care system to its full potential by analysing the late visits and reviewing why this was still occurring at the service. The electronic care system enabled staff in the office to see what time care workers arrived and left the visits. It also aided staff to check that visits were not missed. Every person's schedule and length of visit varied and could be increased or decreased as the care workers became more familiar with the person's needs. The usual minimum time for a visit was 30 minutes. Care workers mainly worked in one geographical area so that they could get to visits on time. The two care workers we spoke with said they had sufficient time, if there were no traffic problems, to get to people's homes.

On the whole staff told us they had enough time to meet people's needs as stated in their care plans. Comments included, "Sometimes the traffic can cause issues getting to people on time, but I always call to let my clients know" and "I believe we are reliable service, the management team will always help out if we are short."

We recommend the provider reviews all visit logs on a regular basis to determine the frequency of the late visits with an aim of reducing future late visits.

Safeguarding procedures were in place. Staff had received training in safeguarding and had a good understanding of the different types of abuse. They told us they would have no hesitation in reporting any concerns to the provider or service manager. They were confident any concerns raised would be dealt with appropriately. The provider told us there had been only one safeguarding incident which had been referred to the local authority safeguarding team by a social worker. The concerns did not relate to any of the care staff.

People and relatives all confirmed that care workers used personal protective equipment (PPE) including gloves and aprons when providing personal care. Care workers understood the importance of infection control and said the service provided them with PPE including gloves, aprons and shoe covers, so they had these to use when attending to people's care.

Incidents and accidents were recorded. These did not occur regularly and the provider explained staff entered any events on the electronic system, which meant the provider could monitor if there were any trends.

Requires Improvement

Our findings

People and relatives told us they had confidence in the staff's abilities. They said staff knew what they were doing and were well trained. They told us the provider was very 'hands on' and worked alongside staff. One relative said, "My (relative) has very complex needs, but the staff all know what they are doing I am very happy with them." Another person said, "The care staff are doing a good job, I believe they have been trained correctly."

At the last inspection in July 2017, the provider told us new staff would complete the care certificate during their induction with Excel Care. The care certificate is a set of standards for social care and health workers aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification). At this inspection we found the care certificate was still not in place. The service manager provided evidence that emails were sent to staff explaining what the care certificate entailed, but no systems had yet been established to ensure new staff completed this as part of their induction. On the second day of the inspection the provider informed us the agency has developed links with an external training provider that will support new staff to complete the Care Certificate. The provider identified the staff that needed to complete this training and confirmed this would take place within the next two weeks. We will continue to monitor the progress of the care certificate at this service.

At our last inspection in July 2017 the provider told us the service had recently changed training providers. They said the new training provider carried out all of the service's mandatory training and that all training was done in a classroom environment. The training matrix showed all staff had completed training in areas such as safeguarding, medicines, dementia awareness, infection control, fire safety, food hygiene and first aid. Dates for refresher training were scheduled. Staff we spoke with said they had attended an induction where they had completed mandatory training and then shadowed experienced colleagues before working unsupervised.

Staff members told us they felt that recently there was more support from the management team. They also told us that supervisions were starting to happen more regularly over the last couple of months. One staff member told us "I feel supported and I know I can always speak to the manager if I have a problem. The manager will at times observe me while I am providing care, to make sure I am doing my job correctly." We saw the service had a system of staff supervision, appraisals and spot checks in place to monitor staff's performance in their role. The provider told us staff had supervision twice a year or more regularly if the staff member requested this. We saw that this was in line with the provider's supervision policy and procedure now in place and reviewed in January 2017.

No one we spoke with had needed any assistance with arranging healthcare appointments. However, people and their relatives told us their care staff would support them if this was required. Care plans reflected people's health and social care needs and demonstrated that other health and social care staff were involved. We saw health and social care professionals such as GPs and district nurses were involved in people's individual care on an on-going and timely basis. Processes were in place which ensured healthcare professionals were involved in regular reviews.

The provider told us they visited and assessed people's needs before the service commenced and this was confirmed in our discussions with relatives. One relative said, "[The manager] came out and spent time talking to us about what we wanted. They've taken on board everything we asked for." We saw evidence of these assessments in the care records we reviewed.

Where it was part of an assessed care need, staff assisted people with their meals. People and their relatives told us care staff asked what they wanted to eat and always gave them a choice of meals depending on what was available.

Staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The 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.

We checked whether the service was working within the principles of the MCA. Everyone using the service had capacity to make decisions for themselves and no-one was subject to a Court of Protection authorisation. There was a policy and process in place which meant people's capacity to make specific decisions could be assessed if necessary.

We saw various consent forms in people's care files; these were for key safes and financial support. Staff told us how they gained people's consent, one staff member advised "I always ask the people I am caring for are they happy for me to complete the required care tasks." One relative said, "The carers will ask consent before doing any task such."

Good

Our findings

People and relatives we spoke with were very happy with the care and support provided to their family members and praised the patience and kindness of the staff. Comments included; "The staff are lovely, I have my favourites", "I cannot fault the care, I am happy with the service" and "The agency is reliable and I do believe the care staff are very kind."

We saw in each care file there was a comprehensive profile of the individual including their likes and dislikes. All staff spoken with demonstrated they knew people's preferences. Staff said, "I like to get to know the people and I feel due to the small size of this service we can provide a consistent level of care" and "I feel the care plans are accurate and clearly tells us what people's preferences are. I would speak to the manager if I noted something wasn't right." One relative said, "The care staff seem to take a genuine interest in [person's name] that's nice to see."

Staff had developed caring relationships with people and demonstrated they knew people`s routines and preferences well. People told us they were offered choices and these were respected which helped people to feel they still retained their independence. For example people were able to say whether they wanted to have breakfast first then be assisted with personal care or what they wanted to eat and drink and what clothes they wanted to wear.

Daily notes captured important information about people's daily lives, such as people's mood and wellbeing, personal care that had been completed and types of meals that had been requested and cooked. However, we noted some of the entries made only consisted of a couple of lines. In discussion with the provider they commented that they were continuing to challenge staff in this area. We noted this was discussed at a recent team meeting with the staff team.

People and their relatives told us they were involved in planning their care and support. They said information about what they required was gathered during their initial assessment. This was confirmed in the care records we reviewed. People we spoke with said if they had any concerns about their care they would telephone the office to discuss them. Everyone we spoke with said the provider and service manager were very accommodating. We concluded people and relatives felt included and were consulted in making decisions about the care they received.

People were asked about their equality and diversity needs. For example, people were asked if they had any religious preferences, how they preferred to identify themselves and if they had any cultural requirements.

Where people expressed any preferences, these were recorded and staff knew how to support the person.

The provider told us that advocacy information was available and kept in the office in case people's needs changed. Advocacy services help people, particularly the most vulnerable in society to access information and services, be involved in decisions about their lives, explore choices and options and help people to defend and promote their rights and responsibilities.

Good

Our findings

When we last inspected the service in July 2017 we found that people did not consistently receive care that reflected their needs and preferences. Although assessments had been completed and care plans reviewed care was not always provided at times people required the support.

During this inspection we found improvements had been made. We found the service ensured people's updated care plans replaced any outdated care plans kept in people's homes. The provider commented that once there was a change in people's needs the care plan would be updated and a paper copy of the care plan would be provided to the person to confirm they were happy with these changes. People told us they were involved in care planning and could ask for changes if they wished. People said, "The manager has recently visited and spent time going through the care plan" and "I have read my care plan, I noticed in the past some of the information about me was not correct, but the manager changed this when I told him."

The provider used an electronic care planning system called the PASSsystem. Excel Care used electronic care system to create care records for people using their service. We saw a copy of the care plan was printed and kept at people's homes. We looked at four care plans held at the office and three at people's homes. We saw that all care plans clearly captured people's assessed needs. We found care plans were updated annually or when there was a change in people's needs. During one visit one person raised a concern that the care staff were meant to be making their lunch time meal. This person's care plan and pre-admission assessment did not state this. The provider confirmed they would speak to the person and their social worker to determine if this additional support was required.

We saw care plans included information about the support people required and the tasks to be completed at each visit. Care plans were person centred, and showed that people's individual preferences had been considered when the care package was developed. There was detailed guidance for staff on how to meet people's personal choices whilst also maintaining their independence as much as possible. For example, in one plan it was stated that although the person required assistance to shower, they preferred to manage their oral hygiene themselves.

Systems were in place to support people if they needed to make a complaint. Each person received a copy of the complaints policy when they started using the service. The policy identified good practice and specified time frames for dealing with complaints. Everyone we spoke with knew the process for raising any concerns or complaints; however no formal complaints had been received.

We asked people if they were aware of the complaints procedure and whether they had ever made a complaint. People told us, "I have never official raised a complaint, I have not needed to. If there has ever been a problem the manager has sorted it out." One person's relative commented, "I have in the past raised concerns about the attitude of one staff member, the manager made sure they never visited here again. I have never had any problems since."

Requires Improvement

Our findings

We took enforcement action after the last inspection in July 2017 and the service remained in special measures. This included serving a Notices of Proposal (NoP) to cancel the registration of the registered manager. The provider put forward representations to the Commission (CQC) in respect of the NoP to cancel the registered manager's registration of the service. CQC upheld the NoP, therefore a Notice of Decision (NoD) was served against the registered manager in which the provider did not appeal further to the First Tier Tribunal. During this inspection we were informed the service manager was in the process of registering to become the registered manager of Excel Care.

At the last inspection in July 2017 we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not have effective systems in place to monitor and assess the quality of care records. At this inspection we found improvements had been made in relation to the quality assurance of the care records and staff recruitment. However, the provider needed to make further improvements which evidenced how they were managing late visits and the auditing of MARs.

At the last inspection in July 2017 we found care staff recorded medicines administered via an app on their smart phone and the electronic care system could only be updated when there was Internet access. If this electronic system was not updated, staff may not be always know if the medicines had been taken during the earlier visit. This meant there was the potential for medicines to be administered incorrectly and cause harm to a person. At this inspection we found the provider introduced a paper version of the MAR which was also completed alongside the electronic MARs, this provided an additional safety mechanism to ensure staff were fully aware of the medicines people had been administered. However, we found the provider had not yet started the process of auditing the completed paper versions and electronic copies of the MARs to determine if these had been completed correctly. During the second day of our inspection we were provided with audits for one person's MAR which indicated there were two missing signatures. We were provided with evidence of what actions the provider had taken in relation to this missed signatures. This included speaking to the staff member in question and reminding them of the importance of completing the MARs.

We asked the provider for a copy of what actions they had taken when late visits had been reported or noted on their electronic system. We found there was no process yet established at the service to follow up on why staff were continuing to be late for their visits to people. Lateness of calls was discussed at team meetings, but the provider did not have a clear overview of the number of late visits people had experienced.

We discussed the inconsistencies of the auditing with both the service manager and provider, who

acknowledged the quality assurance needed to be consistent throughout and they would look to review this areas as a matter of urgency to ensure medicines records were audited efficiently. The provider also commented that they were having discussions with the owners of PASSsystem on how the software will automatically flag to the management when a missed signature on the MARs has been detected or when staff have not logged in at the correct time. We will review the progress of this at our next inspection.

The provider had implemented new quality monitoring systems such as spot checks, care plan audits, training audits and quality surveys. The provider commented that they were looking to increase the number of audits completed with the use of the electronic care system. The provider was looking for this system to produce weekly reports of people's visits, training data, accidents and incidents.

Other actions that had not improved sufficiently were around the quality monitoring of the service. Although feedback had been sought from people who used the service, it had not been routinely analysed and there was no evidence that anything changed as a result of the feedback. Surveys had been sent out to people who used the service and their relatives. We found five were received in January 2018. Comments were generally positive about the service. However, three people indicated that the time of scheduled visits was not consistent. The provider commented that this was a further area they needed to improve on to demonstrate to people how they were planning to make the improvements in respect to timekeeping.

Although some auditing systems were in place, it was evident that there were gaps in the home's quality assurance systems and significant scope for improvement.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from minutes that staff meetings took place every three months which was in line with the service's policy. We saw from these minutes that meetings were also used to deliver training. This should help to ensure that care staff received adequate support required to function effectively in their role.

We looked at the policies and procedures in place to guide staff in their work. These were available at the office and electronically. We asked the registered manager if these were accessible to staff. They told us they highlighted and discussed key policies such as safeguarding and mental capacity during staff meetings. This meant that the registered manager and care staff had accurate and up to date guidance when they were undertaking their support visits.

At the last inspection we found the provider's business continuity plan did not contain specific information relating to how the service would cope with the failure of the electronic care system. At this inspection we found the provider's business continuity plan had been updated, which now reflected the service would also keep paper versions of key documents such as risk assessments, care plans and MAR's in people's homes.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

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 17 HSCA RA Regulations 2014 Good governance Although some auditing systems were in place, it was evident that there were gaps in the home's quality assurance systems and significant scope for improvement.