

Premier Care Limited

Premier Care Limited - Cheshire Branch

Inspection report

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23 March 2018

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 14 and 15 March 2018. 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 adults. We gave the provider 48 hours' notice. This was to ensure that someone would be available in the office as it is a domiciliary care service. Phone calls to people, relatives and staff took place at the same time and following this office visit, up to 23 March 2018. At the time of our inspection there were approximately 177 people being supported with their personal care needs who had a range of support needs such as dementia, physical disability and older people who needed assistance.

There was a registered manager in post at the time of our 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.

This was the service's first published inspection since it was registered at this address. At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Systems in place to monitor the quality of the service were not always effective at identifying and rectifying concerns or changes.

Staff did not always have enough training or knowledge to know how to support people with some specific health conditions.

Guidance was not always available for staff to follow in relations to people's specific conditions, such as diabetes, epilepsy, stoma and catheter care. There was also a lack of information about how to support people with behaviours that challenge.

There was mixed feedback about staffing and the punctuality of calls.

People's medicines were not always managed safely as there were not always instructions available for staff to follow.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed as mental capacity assessments were of varying quality and had not always been reviewed as appropriate. People told us they were asked for their consent prior to being supported.

Care plans and risk assessments were not always updated when necessary and reviews had not always identified omissions.

Lessons were learned as action plans were put in place following feedback from an external consultant about what improvements were required. However action had not always been completed or embedded.

People were supported to have food and drink where necessary. We have made a recommendation about how staff record the support they provide.

People told us they felt safe. People were protected from avoidable harm by staff who understood their responsibilities and had been recruited safely.

Infection control measures were in place as people told us staff took appropriate measures.

People were supported to access other health professionals where necessary, or their relatives were kept updated.

The service checked whether they could support someone prior to the care starting by reviewing information provided to them.

People felt they were treated with dignity and respect. People were involved in decisions about their care and were encouraged to be as independent as possible.

People knew how to complain and felt able to raised concerns. Concerns had been responded to.

The service had made preparations for end of life support, although they did not currently support any one who was nearing the end of their life.

People, relatives and staff found the registered manager and providers to be approachable.

The provider had made us aware that they knew of some of the concerns and were in the process of developing and implementing a new care plan and some technological advancements to improve the service.

Notifications were submitted as required.

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's medicines were not always safely managed.

There were not always plans in place for people who had specific conditions or support needs.

There was mixed feedback about timeliness of calls.

People and relatives told us they felt safe with their regular staff. Safe recruitment practices were followed to ensure appropriate staff were working with people who used the service.

Infection control measures were in place.

Lessons were learned as action plans were put in place following feedback received from an external consultant.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had received training however some staff did not have specific health-condition knowledge or training to be able to effectively support people.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed as mental capacity assessments had not always been reviewed appropriately but people were asked for their consent.

People were supported with their nutritional intake where appropriate.

People had access to health care services.

The service checked they could support someone prior to starting to visit them.

Is the service caring?

Good ●

The service was caring.

People told us the staff were kind and caring. People told us they generally had the same staff visiting.

Privacy and dignity were respected and people were supported to maintain their independence.

People and relatives were involved in decisions about care.

Is the service responsive?

The service was not always responsive.

People did not always have their plans updated when necessary.

People knew how to complain and felt able to.

The service had made preparations for end of life care.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Quality monitoring systems were not effective at ensuring the service was being managed appropriately and safely.

People and relatives were asked for their opinion about their care.

People, relatives and staff felt the management of the service were approachable.

Requires Improvement ●

Premier Care Limited - Cheshire Branch

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The office inspection took place on 14 and 15 March 2018, with phone calls to people and relatives on the same days and follow up calls to staff up to 23 March 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection was carried out by three inspectors. There were also five Experts by Experience who made phone calls to people who use the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners if they had any information they wanted to share with us about the service.

We spoke with 24 people who used the service, 20 relatives and 11 members of staff that supported people. We also spoke to the registered manager, the head of governance and a director. We reviewed the care plans and other care records (such as medicine records) for 14 people who used the service. We also looked at management records such as quality audits. We looked at recruitment files and training records for seven members of staff.

Is the service safe?

Our findings

People told us they received their medicines. One person said, "Yes, I have tablets. Staff give them to me with a drink and make sure I have them – before breakfast and at teatime." Another person said, "Care staff always prompt my meds, even though I self-medicate they always ask me." Medication Administration Records (MARs) were used by staff to record when they had administered or not administered a person's medicines. However, we found the documentation was not always clear or fully completed. Some MARs were hand written and the medicine name was not clear, there were not always dosage instructions, instructions where to apply topical medicines or the frequency a medicine was required. We spoke with two staff who said they had training, which was updated, about administering medicines safely. Their replies to how they managed short term or emergency medicines were inconsistent. When we spoke to one of the directors about medicines they explained new printed MAR sheets were being introduced to reduce any issues occurring with hand written MAR sheets. However, we saw some completed printed MAR sheets and there were still omissions. For example, how frequently a medicine needed to be administered. Staff had also added some handwritten medicines onto these printed MARs without clear instruction. The recording of the administration of medicines on both versions of the MAR was sometimes confusing and unclear. Therefore we could not be sure that people were always receiving their medicines as prescribed as records did not support this. Some medicine is applied or taken as and when required, sometimes called 'PRN medicine'. There was no personalised information for staff as to how to identify when PRN medicine was required for the person they were supporting. This meant documentation was not always clear for staff to follow which put people at risk of not having their medicines correctly.

There was mixed feedback about timeliness of calls; however no one told us they had experienced a missed call. Some people told us they did not experience any late calls. For example, one person said, "Virtually, yes [carers are on time], within 30 minutes," and a relative said, "Yes carers are on time, give or take 15 minutes." Another relative said, "Yes carers are on time, give or take 15 minutes; they've never missed a visit." However, some people told us there was no consistency with calls times. One person said, "My visit is arranged for 9:00am but sometimes they're very late; sometimes it's 12:00 before they come. I can't get dressed if it's on one of my days for a shower, and I get cold; and if anyone's [i.e. a visitor] coming it's a bit awkward." Another person said, "The times change so sometimes my breakfast call can be 11am, should be 9.30am, then my lunch call is then too close." Some staff we spoke with said they struggled to get to calls on time. One staff member said, "We don't have enough staff. There are too many morning calls for one person so I end up late and doing morning calls at lunch time." Another member of staff said, "I run late most runs. I'm only on time for my first call." Another member of staff said, "I have to use leftover call time to be used as travel time. I have to pinch a bit of time from calls to travel." The provider also used a monitoring system where carers logged in and out of visits using company mobile phones and the scanning of a unique code on people's care files in their homes.. These records showed there were some occasions whereby staff were very late for visits. We could not see what direct action had been taken to resolve these particularly late calls. This meant some improvements were necessary to ensure all people experienced timely care.

Staff had mobile phones supplied to them by the company, these contained information about the staff member's rota and details of what should be carried out on each visit to each person. We found that some

plans, both those on staff phones or the ones in people's homes, did not contain enough detail about people. Some people had specific health conditions, such as diabetes, epilepsy and support with a stoma or catheter. However we found there were not always plans or risk assessments in place to assist staff. For example, records showed a person who had diabetes and was 'at risk of hypo' (hypoglycaemia) did not have a care plan to help staff know what signs and symptoms they should look for, or what to do if they suspected the person was hypoglycaemic. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming more ill. Another person had a stoma; a stoma is an opening on the abdomen that allows waste (urine or faeces) to be removed from your body. There was limited detail in the person's plan about how staff should support the person with their stoma. This meant the person may be at risk of receiving inconsistent care and staff not supporting the person in line with guidance. In another example, one person had a catheter; staff were to empty the catheter bag during each visit, however there was no further detail as to what other support the person needed in relation to their catheter and who was responsible for this. This meant the person may be at risk of not receiving the support they required to maintain their wellbeing. In a further example, one person had epilepsy but there was no guidance about how this may present itself and how staff should react should the person have a seizure whilst staff were present. This meant the person was at risk of becoming unwell as staff may not recognise the symptoms of a seizure and may not take appropriate action. Some staff told us that some people could experience behaviour that challenges and could be aggressive towards staff. We also saw that some people had been identified through the assessment process as having behaviours that challenge. Staff told us and we saw that there were no plans for them to follow to be able to assist some people to become less agitated. This meant people and staff were at risk as staff did not have appropriate guidance to know how to support some people to become less agitated. This showed there was a risk to people's health and wellbeing as staff did not always have sufficient guidance to support people effectively.

We saw that the service was learning when things had gone wrong. An external consultant had visited to carry out an audit. An action plan had been put together following the consultant's feedback in order to address some areas that had been highlighted for improvement. For example, one action was to develop a new PRN protocol. We saw a new protocol had been developed but it was not being used consistently and was not always completed correctly. Therefore continued improvement was required and improvements needed to be embedded.

People told us they felt safe and relatives confirmed this. One person said, "I feel very safe that they come and see me. Other people said, "I feel absolutely safe – the carers are smashing, great" and a relative told us, "I feel my relative is safe with the staff as they know their needs." Another relative said, "I feel I can go out and my relative is in safe hands." People were protected from avoidable harm by staff who understood their responsibilities to keep people safe. Staff could describe different types of abuse, the signs to look out for and what they would do if they suspected someone was being abused. We saw appropriate referrals had been made to the local safeguarding authority and there was a safeguarding policy in place. That meant staff and systems helped protect people from avoidable harm.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) (criminal records check) to make sure people were suitable to work with people who used the service. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. We saw appropriate risk assessments were in place if a member of staff had a positive DBS.

People told us that staff followed infection control guidance by wearing aprons and gloves when necessary.

One person told us, "The carers wear gloves and aprons when they're washing me." Another person said, "They wear plastic gloves when they're helping me and when they're doing anything with food." We saw that staff received infection control training and there was a policy in place. This meant infection control measures were in place to help protect people.

Is the service effective?

Our findings

People and their relatives had mixed views about whether staff were well-trained. One person said, "The staff know what they are doing, very happy." One relative said, "My relative's two main carers are skilled and experienced" and, "The carers appear to be competent and I think they're well-trained." However another relative said, "Staff are taken on having had 30 years' caring but the knowledge of the individual's needs is important. If I have a criticism, I would say the company is inclined to assume that the carer doesn't need training up on individual needs. You can't apply general rules to individuals." Whilst a further relative told us, "I would like to see more training. New carers need training in the individual's specific requirements."

However, we found staff were not sufficiently trained to be able to support people effectively. Some people had specific health conditions they may have needed support with. We found staff had not received training in specific conditions for example, diabetes and epilepsy; staff told us they had not had training about these conditions despite supporting people who had the conditions. One person had noted in their care plan that they had diabetes. However some staff were not aware of this, despite the condition being noted in the care plan for a period of time whilst staff were supporting the person. One member of staff said, "We only recently found out [person's name] was a diabetic. We were doing their shopping and realised the food wasn't appropriate when we realised the person was diabetic. We do appropriate shopping now." When we asked staff if they would be able to recognise the signs of someone having low or high blood sugars they were not always able to tell us. One member of staff said, "I wouldn't have a clue" when they were asked about recognising symptoms for someone who was becoming unwell due to high blood sugars. When we asked the member of staff about what they would do, they said they would call 999 and that the person, "knows what to do themselves." However, if someone is very unwell from low blood sugars, they may not always be able to tell staff what to do. One person who was noted as having diabetes had been found on the floor by a member of staff who assisted the person back into a chair. The staff member did not record if they had asked the person why they might have fallen, checked for injuries, or prompted the person to check their blood glucose. This shows staff did not always know what action to take. When we asked staff about whether they had guidance about a person's epilepsy they responded, "Well, what would I do if [person] has a seizure while I'm there?" Some people had behaviour that challenged. Staff told us they had not always had training to know how to support people with their health conditions or behaviours. One member of staff said, "No I don't think we have had training. We take it upon ourselves to try to calm [person] down." Records confirmed staff had not received training in this area. This meant people were at risk of not being supported appropriately with their behaviour and staff were at risk as they had not had sufficient training. This put people's health and wellbeing at risk as they may not always be supported effectively with their health conditions or needs. The provider explained that staff did have some training around people's mental health needs during staff induction, however due to staff telling us they felt they did not always know what to do and some relatives confirming this, it meant this training had not been effective at enabling staff to support people effectively.

These issues demonstrated a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 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. Decision-specific mental capacity assessments should also be undertaken to determine if people have the capacity to make certain decisions, for example in relation to their care or the taking of medicines, if it is suspected that the person may lack capacity.

We found that mental capacity assessments had been carried out however some were not fit for purpose or had not been reviewed appropriately. However, people told us staff asked for consent before supporting them. One person said, "The carers do ask you if you want help. They say things like "Would you like your shower now?" and "Are you ok if I give you your tablets?" They're always very polite." A relative said, "The carers do talk to my relative and realise that they can understand even though they can't say very much. My relative can say yes and no, and [the carers] recognise their facial expressions."

Staff told us the MCA paperwork was not always clear. For example, one member of staff said, "The [MCA] forms we've got are no good." The registered manager told us one person lacked capacity. We looked at the person's care file and we saw a mental capacity assessment that stated the person had capacity in March 2017 but this had not been reviewed since, despite the registered manager being aware the person no longer had capacity. Another person had been assessed as lacking mental capacity to make decisions but on the same day as the assessment, had signed forms to consent to medication being administered by carers and to their plan of care. Another person had a mental capacity assessment that was incomplete and had conflicting information. We found when people had been assessed as lacking capacity it had not always been assessed in relation to specific decisions, as required by the MCA. Plans were not always in place to help staff care for the person effectively. The provider told us that new decision-specific assessments had been developed. The provider and registered manager were in the process of introducing these forms, particularly for new people they started to support, followed by people they were already supporting. However, appropriate reviews had not always been taking place when people's needs had changed and the new assessments were not fully embedded. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. We saw an example where a relative had signed consent on behalf of someone who did not have capacity but there was no evidence that they had the legal right to. We also saw another example of a person who did have capacity but it had not been recorded that the person had given permission for their relative to sign consent on their behalf. This meant the MCA was not understood and consistently applied and people's rights were not always protected.

The service relied mostly on pre-admission assessments made by a Local Authority social worker to determine if they were able to meet the care and support needs of people before accepting responsibility to provide it. Assessments were then made once the support started. However, we found that these assessments did not always provide an accurate reflection of the care that people required. People were at risk of receiving inconsistent care. One person's assessment and plan stated they needed their fluids recording but this was not necessary and had never been done by staff, but this difference had never been identified. The same person was being supported by staff to apply cream however this information was not reflected in their care plan or on the summary sent to staff on their company mobile phones. This meant the assessments were not always effective and some plans had omissions which could lead to the person receiving inconsistent care.

People told us they were supported with their food and drinks where appropriate, although many people were able to prepare their own meals or were supported by family members with this. One person said "I like

all my carers and they always ask me what I would like to eat and drink." Another person said, "Staff ask me what I want for my meal" and someone else said, "They always ask me what I want to eat and they leave me a drink before they go." Another person told us, "I have ready meals and the carers will come and say "Which one would you like?" or "Tell me what you want". They usually make me a cup of tea just before they go." A relative told us, "It's only a microwave meal that I usually choose before they come but they are always willing to help with anything we need." We saw plans contained prompts to staff if people needed support to prepare food. However, we saw in one person's care notes that staff were recording they were giving food which appeared to not be appropriate for their needs. They were assessed as needing soft and moist food. When we spoke to a care coordinator about this they explained it was the way staff were recording the food which was not clear. For example, staff recorded they were giving the person a pasty, which is pastry and would not be appropriate for someone on a soft diet. However it was explained to us the staff only supported the person to eat the pasty filling, rather than the pastry. It is recommended that staff clearly record how they are supporting people to eat to ensure that people are supported effectively. This meant overall people were supported to have food and drink where necessary.

People and relatives told us that other health professionals had been involved with people's care when necessary. One person said, "The other day [the carer] rang for the doctor and told them [what was wrong]. The doctor came out and gave me antibiotics." Another person said, "Once, I think, the carer said she thought I needed to see the doctor, which I did." A relative told us, "If there's something wrong, with my relative's skin etc, they'll draw my attention to it. Or they'll tell me if we're running out of skin cream." Another relative said, "The carers ring me up if there are any issues. They are very happy to talk to us, and us to them." We saw evidence of other health professionals being involved, such as district nurses and social workers. We saw that action was taken when a concern had been identified. For example a person had a problem with their skin, district nurses gave advice on how the person should be supported with this on a temporary basis and the information was shared with staff via a message to them on their work mobile phones. This meant people were supported to access other services where necessary.

Staff received an induction when they started working for the service which included shadowing. A relative said, "When you get a new carer, they shadow them for a while, depending on their previous experience. They tell and show them, rather than sit down with the care plan. Newer carers usually come with someone more experienced." Staff we spoke with who were nearing the end of the first part of their induction told us, "I feel much more prepared now." Staff told us there had been a period of time when they did not have supervisions or support; however they felt support had improved since the new registered manager had started. One member of staff said, "I've had a 1 to 1 with the manager. I like them, they're there when needed."

Is the service caring?

Our findings

People and relatives overall gave us positive feedback about the staff that visited them. One person said, "[The carers] are very nice and some are quite giggly – we have a bit of fun. I've never had a wrong word from them." Another person said, "[The carers] are great – you feel like you've known them for years; very friendly and kind." Another person told us, "I am happy with my carers, they are nice people, always chatty and smiling. If I'm feeling a bit fed up they will always do something to make me laugh." One relative said, "The carers show my relative empathy. They don't make them feel like a nuisance. The staff are very good at that sort of thing. No one has ill-treated my relative." Another relative said, "It's like having two friends [the staff] coming with their stories. They get my relative talking. By the time they've left my relative is awake and ready for the day"

People and relatives told us that they generally had the same staff and this was beneficial. One person told us, "Having a stable team is brilliant." Another person said, "Continuity is good." One relative said, "The best thing is that my relative has the same person all of the time. It puts my relative at ease. [Relative's name] is happy and content with the care. They are not depressed or anxious." Another relative told us, "My relative gets the same carer ninety percent of the time, which is good as they have got to know my relative. The carer is nice." Another comment from a relative was, "Same group of carers, which is good."

People and relatives told us the staff treated them with dignity and respect. One person said, "Staff respect me and my home." Another person said, "If I go to the toilet, the carers will shut the door." Someone else said, "The carers always make sure the curtains are closed [when giving personal care]. They are all very nice." Another person told us, "They always treat me with dignity and respect when they help me have a wash and get dressed, they ask me what I want and what I need." Staff we spoke with were able to describe and give us examples of how they would help people retain their dignity whilst being supported.

People told us they felt they were supported to maintain their independence. One person said, "When helping me with washing and dressing they always let me do as much as I can for myself. They just help with the bits I can't. I don't want to become too dependent and they know that so they are patient and don't rush me." Someone else said, "Having the care staff encouraging me to do as much as I can is a good thing to keep me active." Another person told us, "I wash my own hair when [the carers] are helping me with a shower." Someone else told us "When I'm in the shower, I wash myself all over but [the carers] do my back." Another person commented, "I do a lot for myself but it's nice to know that they are there if I need help. They don't rush me at all." This meant people were encouraged to retain their independence and do what they could for themselves.

People told us they felt involved in decisions about their care. One person said, "The staff encourage me to make decisions." Another person said, "My views and likes and dislikes are taken into account." Someone else said, "I was involved in the care plan and reviews." Someone else told us, "Staff do listen to you; if I think there's something wrong, they'll listen and help me." A relative also said, "Care planning was good, I could give my views."

Is the service responsive?

Our findings

Most people we spoke with told us they had reviews of their care plans. One person said, "The carers make sure what they're doing is right – they check the book if they're new, and they do ask you. I was asked if I would be happy with a male carer, and I said no." One relative said, "The coordinator came out a couple of months ago to review the care plan. [My relative] was present and I spoke on their behalf." Another relative said, "My relative was originally involved with the care plan but it's mostly me now. Last review the manager just rang up and asked if I was still happy with it and if anything had changed." However, despite some reviews taking place these were not always effective or in a timely manner in response to people's needs changing.

Care plans did not always include up to date information which could lead to people having inconsistent care and reviews had not always identified omissions. One person said, "The care plan is not that detailed and not that specific. But I don't spend a lot of time looking at it. Generally the care is good." One member of staff told us, "Care plans are well out of date. We then struggle as plans have not been reviewed." Another member of staff said care plans, "Are not always up to date." One of the directors we spoke with said, "Practice in the field is probably not reflected in the paperwork" and they went on to say, "I've got a good feeling what's going on in the field is great but lacking with paperwork." For example, one person had noted on their care plan that staff needed to document the person's food and fluid intake, however this was not required and staff had not been recording this since the care plan had been written. Reviews of the care had not identified that this was not being done. Some risk assessments were not always updated when people's needs had changed. For example, one person's medicines risk assessment stated their relative dealt with all the medicines but this had not been reviewed following a change in circumstances and staff were now involved. The care plan also did not reflect that staff were supporting people with their medicines. This left the person at risk of receiving inconsistent care and the staff did not always have up to date information.

There was an 'Equal Opportunities' policy in place which took account of the protected characteristics (such as gender, race, religion, sexuality etc), as well as an 'Equality & Diversity' policy. However, the service could not always demonstrate how they were effectively supporting people with maintaining same-sex relationships or ensuring people could be open regarding their sexuality, if they chose to. The provider told us, "We as an organisation need to be proactive in ensuring people are treated equally and do not suffer discrimination." However, when we spoke with people no one raised a concern to us regarding how they were supported in relation to any protected characteristics. The provider also explained to us that they recognised it can be a sensitive subject for some people and some people may not want to discuss this, which is their individual choice.

Despite plans not always containing up to date information, many people and relatives said their regular staff knew them well and supported them in a way they liked. One person said, "If I ask the carers for anything, they'll do it." Another person said, "We know a bit about the carers and they know something about us." Another person commented, "I think they are very kind and I think their way of helping me is just right." One relative said, "I'm very happy [with the care] and they're supportive, flexible, help with whatever's needed. It's the little things they do sometimes, that count." Another relative said, "Very accommodating

staff." Another relative commented, "The staff all, more or less, know what's needed."

We saw people were supported to communicate and access information, such as their care plans or risk assessments in alternative formats, such as larger print or a member of staff would go over it verbally with the person. One relative told us, "My relative is learning to use a communication aid, and if the carer has time, they will sit and have a go with them." This meant people were supported to access information in a way suitable for them.

People and relatives told us they felt able to complain. One person said, "We've got all the phone numbers. I've only complained once, when the carer was very late. They did apologise, I think." Other comments included, "Any concerns I would call the office" and, "Any complaints are dealt with." One relative said, "I haven't made a complaint. If I had a concern I speak directly to the carer and if they understand, fine. I would speak to the manager if I needed to." Another relative told us, "I've never had to complain but I would say it straight out to the carer first and ring the office if I needed to; the phone numbers are on the front of the file. There's probably a complaints policy in the file, I think." Other comments from relatives included, "Staff and office staff always listen to me and try and help me" and, "Any issues I call the office and they will help me." We saw that complaints had been recorded, a log made of complaints received and responses had been sent. We also saw an appropriate complaints policy was in place. This meant the provider and registered manager would learn from and respond to complaints in order to improve the service.

At the time of our inspection, the service was not supporting anyone who needed end of life care. However a policy and procedure was in place which set out the service's responsibility and expectations of supporting people and their relatives at the end of a person's life. This included the consideration of pain relief, the need to work with other agencies, additional support required and supporting relatives.

Is the service well-led?

Our findings

Systems were not effective at identifying changes in people's needs or a change in the support staff were giving to people. Information was often not included in people's care plans and changes were not being identified in audits of daily care notes. Care notes were also not always being audited in a timely manner. We spoke to a member of staff based in the office about how frequently care notes were returned to the office. They said, "If the care coaches go out [senior staff] they'll empty the folders when they notice them." We saw in care notes, for example, staff were documenting that a person was being supported to have creams applied and being supported with their skin integrity. The care notes including these details had been audited however these details were not identified and updated within the person's care plans. Another person was having their food recorded in their care notes that did not appear to be appropriate for their needs; however this had not been identified through audits. This left people at risk of receiving inconsistent care and showed that audits were not always effective.

'Spot checks' on care files had been taking place, however these had failed to identify when essential information was missing or when the care being delivered did not match the care plans. For example, reviews had taken place on the plans for people who had specific health conditions however the checks had not identified that there was often limited or no information to guide staff how to effectively support people and to keep people safe. One relative said, "There needs to be prior knowledge of the individual's needs and attention to detail." It had also not been identified that staff did not always have the knowledge to support people effectively, particularly in relation to specific health conditions and knowing how to recognise some symptoms or action to take if a person presented as unwell. This left people at risk of receiving inconsistent care, showed that spot checks were not always effective and there was a lack of oversight in relation to additional training needs of some staff.

There was limited evidence that people's Medicines Administration Records (MARs) were being regularly audited. We saw examples of hand written MARs and some examples of printed MARs which had been introduced to try to reduce human error. However, we saw a lack of detail and poor and unclear recording on both MAR formats so we could not be sure that either system was effective and embedded sufficiently in guiding staff and ensuring staff were accurately recording the administration of prescribed medicines to help people maintain their health and wellbeing.

The falls risk assessment documentation was poor. It was not clear how it should be completed; it had been completed differently by different staff and had not been reviewed in line with the timeframes set by the provider. When we spoke to one of the directors about this they told us of new care plan and risk assessment documentation that was being developed. The director said, "If we thought it was perfect, we wouldn't be developing a new system." We saw a draft copy of the new documentation however this had not yet been implemented and we could not see any completed examples to check it was effective. This meant some issues had been identified by the provider but these were not yet embedded and people were at continued risk of receiving inconsistent care.

There was limited evidence that audits on the quality and content of care files and daily records were being

undertaken by the registered manager or provider. The registered manager was new in post and had not yet had sufficient time to audit care files. However, the provider had also not undertaken these. When we asked the registered manager about this they said, "I check new care plans and sign them off. There is very little I have gone over yet." The registered manager did explain they reviewed any information added to their system following a phone call, for example. However, there were limited quality assurance processes yet in place to verify whether checks on care notes, for example, carried out by other senior staff were effective. Audits in relation to electronic data, such as call durations, punctuality and carer continuity were being undertaken by the registered manager. However, the analysis had not identified the concerns we found or led to improvements.

Some of the provider's own policies had not always been followed. For example, the 'Managing Challenging Behaviour' policy stated staff would have training opportunities to develop their skills and knowledge but this had not always happened. The 'Staff Supervision & Appraisal' policy stated staff should have a supervision a minimum of six times per year, including their annual appraisal, but this had not always been happening. One member of staff had an additional risk assessment in place to ensure people were protected, however we saw this risk assessment was not always being followed. It stated they needed additional supervisions but there was no evidence that these had been happening. People's mental capacity assessments had not always been reviewed when necessary and documentation was sometimes unclear.

These issues demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had arranged independent audits to take place to check the quality of the service. These had identified areas of concern and an action plan had been developed to try and address these. The provider was also in the process of designing new care plan documentation and piloting with a view to implementing new technological systems to improve guidance to staff and reduce human error. Regular branch review meetings regarding the performance of the service had not been taking place however these were being re-introduced to ensure regular oversight from the provider. However, action had not yet been fully taken or had not yet been embedded.

Some staff told us they had not had a supervision in a long time. However with the introduction of the new registered manager some staff had noticed an improvement and they felt there was now more opportunity to discuss things. One member of staff said, "The registered manager is brilliant, before there was no chance of support but the registered manager is very approachable." All staff we spoke with were complimentary of the registered manager and felt they could go to them or the provider, such as the area manager or directors. This meant improvements were being made and staff were feeling more supported, but policies were not fully embedded and always being followed.

People and relatives told us they felt able to give feedback and were asked for their opinion about their care. One person said, "I have been asked for feedback." Another person told us, "The office ask me how the care is." Other person commented, "Somebody rang a while back and asked questions over the phone." Comments from relatives included, "They welcome feedback" and, "All staff very approachable." One relative also said, "I have been rung by the head office, not long ago, for my views." We saw evidence that people had been contacted about their opinions and these responses had been analysed.

People and relatives found that the service was improving and that staff and the registered manager were approachable, although not everyone had yet spoken to the registered manager as they were new. One relative said, "Within the last twelve months there has been a huge improvement. Before that the whole

place seemed to be in chaos. Now they seem to run a tight ship. The administration is infinitely better." One relative said, "All of the staff are approachable and the office staff are fine when you ring them about something. I've spoken to the manager and they are very open and approachable." Another relative said, "The carers are approachable. It's knowing who the managers are now. We have had a letter to say [name] has taken over but haven't yet spoken to them." Staff were also complimentary of the management of the service. One member of staff said, "Because the new manager was a carer they understand the role. It's like a family. If the manager is on holiday I can go to the area manager or a director." We saw evidence that staff meetings were taking place and staff had the opportunity to get together to discuss their rotas and the people they supported. Staff also confirmed they had spot checks and we saw evidence of this. This meant steps were being taken to monitor staff competencies.

The registered manager was notifying CQC about significant events that they are required to notify us of by law. We use this information to monitor the service and ensure they responded appropriately to keep people safe.

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 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not effective at identifying and rectifying issues and ensuring the service was being managed appropriately and safely.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had received training however some staff did not have specific health-condition knowledge or training to be able to effectively support people which left people and staff risk.