Nestor Primecare Services Limited

Allied Healthcare Plymouth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Allied Healthcare Plymouth is a domiciliary care agency. It provides personal care to people living in their own homes. It currently provides a service to children, and younger and older adults who need support with their personal care and/or have complex clinical healthcare needs. The service supports people within the localities of Cornwall, Plymouth, Barnstaple and Exeter. The service is owned by Nestor Primecare Services Limited, who have 83 branches across the UK.

Not everyone using Allied Healthcare Plymouth received a regulated activity; 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 time of the inspection there were 99 people receiving personal care.
The inspection was announced and started on 22 March 2018 and ended on 19 April 2018. 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 available in the office. It also allowed us to arrange to visit people receiving a service in their own homes.

Prior to our inspection we received concerns about poor staffing arrangements within the service. So this was looked at, as part of our inspection. The provider had already recognised improvements were required, so as a result had made changes to the structure of the organisation, by registering the service in Plymouth, and had recruited a new manager. The new manager had applied to the Commission to become the 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.

Staff told us since the recruitment of the new manager, they felt confident changes would be made and improvements seen for them, and for people using the service. Staff, were complimentary of the new manager, and of their kindness and passion, with one member of staff commenting, "Hopefully we have turned a corner and going forward. I think the manager, seems to be competent, confident and knows where she wants to get the company".

The new manager was supported by the operations manager, and weekly meetings were held to discuss the compliance and financial accounts. Whilst the new manager told us they felt supported, they had not received a formal management induction into the organisation. This meant the manager may not be aware of essential policy and procedures pertaining to the day to day management of the organisation.

Whilst staff recognised how busy senior managers were, some staff told us they did not feel supported by the operations manager. Despite the provider having a comprehensive governance policy and quality assurance framework in place to help monitor the quality and safety of the service, which included a variety of audits. It had failed to promptly identify the areas requiring improvement. It had also failed to identify the

in cohesive culture of the organisation.

Staff told us, they felt they worked for the 'branch' and did not feel part of the bigger organisation. The provider's vision statement was, "To be the choice for care that give people the freedom to stay in their own homes". However staff, were not aware of this statement, which demonstrated staffs lack of engagement with the wider organisation. Despite an employee recognition scheme, staff did not feel their contribution was valued.

People, staff and the public were involved in the ongoing development of the service. Surveys were sent to people to obtain their views, and feedback was collated. At the time of our inspection, no recent survey had been carried out.

The failings identified as part of this inspection demonstrated that the provider did not ensure that continuous learning took place to facilitate improvement. However, the manager attended a weekly meeting to discuss the provider's ongoing improvement plan, making sure it was being completed and starting to have an impact on the overall quality of the service.

There was a confidential safeguarding and whistleblowing line which staff could use to raise concerns and whilst staff told us they would feel confident about raising concerns, they had failed to raise concerns about the culture of the service.

People told us there were not enough staff and told us they were not always informed of who would be arriving to support them. Whilst some staff told us they had enough traveling time, some staff told us they did not. The operations manager told us a staffing analysis was being carried out to look at how staff, were deployed within the service. They also told us they recognised that people's care was being commissioned in a different way, and as an agency they needed to be receptive to that, and make changes accordingly.

People's risks associated with their care were known by staff, such as how people needed to be moved by the use of moving and handling equipment. However, people did not always have risk assessments in place relating to health risks. This meant people may not be supported safely and/or with continuity. People had environmental risk assessments in place, which detailed any risks to staff, such as pets, trip hazards, or poor outside lighting.

People told us they felt safe when staff entered their home, with one person telling us, "They are very trustworthy". Staff, were supplied with a uniform and an identification badge so they were recognisable. People who had a 'key safe' had their details held securely.

People were protected from abuse. Staff had undertaken safeguarding training, and knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff had been recruited safely to ensure they were safe to work with vulnerable people.

People's medicines were managed safely. Overall, people were protected by infection control procedures to help reduce the spread of infections. Staff had undertaken training and told us there was always a good supply of personal protective equipment (PPE). However, one person told us they had to buy their own gloves as they were allergic to the silicone gloves staff used, and explained staff did not always wear PPE.

People told us staff had the right skills to meet their needs. However, despite the provider having a comprehensive induction programme, two members of staff told us that they had to 'learn on the job'. With one of these members of staff having never worked in the health and social care sector.

Staff had undertaken training the provider had deemed as 'mandatory'. Staff, who supported people with clinical needs, received healthcare training and staffs ongoing competency was assessed by specialist nurses, employed by the provider. Staff, were complimentary of the training they received, but told us they had not received supervision of their practice for some time. The manager recognised this, and already had a plan in place to rectify this.

People's health and social care needs were assessed to help ensure their needs were met. People were supported to obtain help from external professionals if their care needs were changing.

People's human rights were protected. People were assessed in line with the Mental Capacity Act 2005 (MCA), to check their ability to consent to their own care and treatment. People's care plans provided detail about their mental capacity and how this impacted on the decisions they made.

People's individual communication needs were known by staff, and staff described how they adapted their approach to each person. People's care plans supported staff to meet people's individual needs. However, one person who was unable to read had not been provided with a care plan in a suitable format. This demonstrated the provider had not fully considered the Accessible Information Standard (AIS). The AIS is a national requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.
When required, people were effectively supported with their nutrition and hydration. People's likes and dislikes had been recorded and people told us staff listened to what they wanted, and accommodated there requests.

Overall people's privacy and dignity was respected. Staff explained how they promoted people's privacy and dignity, by closing curtains and shutting doors. However, one person told us that staff did not always do this, and had at times, called out for staff to return to the room to cover them up.

People were supported to be part of decisions relating to their care. Checks of people's care helped to ensure people were satisfied with how they were being supported. However, people's views were not always respected or listened to.

People told us, staff were kind, commenting "I have the highest respect for these carers, they're very good, I have no worries or concerns about them at all", and "They always sit down, and we have a chat and a cup of tea".

Staff spoke fondly of the people they supported, and displayed passion for their job. One member of staff told us how they had flexibly changed their visit time to enable one person to enjoy a lie in.
Staff had received training in the Human Rights Act 1988 and explained how they supported people in the same compassionate way, regardless of their gender, sexuality or ethnicity.

People's independence was promoted, staff told us how they encouraged people to do as much for themselves as possible. One person commented, "They encourage my independence", and a relative explained, "They seem to be encouraging her independence".

Overall, people had a care plan which had been constructed with them. People's care plans detailed information for staff to help ensure people received the care they needed and wanted. However, for one person we visited, who required support with their moving and handling and clinical care needs, they did not. We requested a care plan was put into place within 48 hours, which occurred. People's care plans were reviewed with people, however one person told us how parts of their care had not been discussed with

them, and there were aspects they would have liked further support with.

Staff told us, people's care plans were not always up to date and reflective of people's care needs, with one member of staff telling us of a care plan which had not been updated in a few years. They also told us they did not always read people's care plans, because they did not always have time.

Overall, people's concerns and complaints were listened to. People told us they knew who to contact to complain. However, some people told us when they contacted the office they did not always get a response to their concern, with one person telling us, "There's no point calling the office, they don't do anything, they say they're doing something about it, but they don't and they never call back".

We found two breaches of our regulations during this inspection. We also recommend the provider takes account of the Accessible Information Standard (AIS) and uses it to help improve the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

People's risks associated with their care were known by staff but not always recorded to help ensure people's care was managed safely and with continuity.

People told us there were enough staff to meet their needs, but staffing changes were not always communicated so they did not always know who was arriving to support them. Staff told us they did not always have enough travel time and on occasions, felt under pressure when they were driving.

People were protected from abuse, and told us they felt safe when staff entered their home.

People's medicines were managed safely.

People were protected by infection control procedures to help reduce the spread of infections.

The provider learnt when things went wrong, in order to improve the service.

Is the service effective?

Good

The service was effective.

Overall, people's needs were met by staff who had the right skills and experience.

People's health and social care needs were assessed to help ensure their needs were met. People were supported to obtain help from external professionals if their care needs were changing.

People's individual communication needs were known by staff.

When required, people were effectively supported with their nutrition and hydration.

People's human rights were protected in line with the Mental

Health Act 2005 (MCA).

Is the service caring?

Requires Improvement

Aspects of the service were not caring.
People's privacy and dignity was not always respected.

People were supported to be part of decisions relating to their care, but their views were not always respected or listened to.

People told us, staff were kind.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People did not always receive personalised care which was responsive to their needs, and staff did not always have time to read people's care plans.

People's concerns and complaints were not always listened to.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

People told us the administration of their care was disorganised, and that their phone calls were not always returned.

People received a service which was not effectively assessed or monitored by the provider, to ensure its ongoing safety and quality.

Staff told us there was not always a positive and inclusive culture, and that they did not feel valued.

People, staff and the public were involved in the ongoing development of the service.

There was continuous learning taking place to help facilitate improvement.

The provider worked in partnership with external agencies in an open and transparent way, for the benefit of people.

Allied Healthcare Plymouth

Detailed findings

Background to this inspection

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

The inspection was announced. It was undertaken by two inspectors, five experts by experience and a specialist advisor for nursing care. 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 our inspection we reviewed the information we held about the service. We also contacted Healthwatch Plymouth, the local authority quality and service improvement team (QAIT), and commissioning teams for the local authority and clinical commissioning group (CCG), to ask if they had any feedback about the service. Where feedback was provided, it can be found throughout the inspection report.

We gave the service 48 hours' notice of the inspection visit because we needed to ensure that there would be someone in the office to support the inspection process. It also allows us to arrange to speak and visit people receiving a service in their own homes. Inspection site visit activity started on 22 March 2018 and ended on 19 April 2018. We visited the office location on 22 and 23 March 2018, and on19 April 2018 to see the manager, office and care staff; and to review care records and policies and procedures.

During our inspection, we spoke with 29 people on the telephone to obtain their views and visited five people in their own homes. We also spoke with 18 members of staff, the branch manager, the operations manager and regional director.

We looked at six people's care records, training records, staffing rotas, policy and procedures and the provider's monitoring checks.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received concerns about poor staffing arrangements within the service. So this was looked at, as part of our inspection.

People told us there were not enough staff telling us, "A few weeks ago I had to sleep in my clothes because the carer could not get to me, she rang to tell me that she had to stay with someone who had been taken ill", "There has been a few changes, a few problems with people leaving" and, "They missed one visit to me, but made up the hours the following week". Another person told us, "Normally I get the same carers every week, it's the same girls I've had for two to three years but last Sunday they didn't turn up, they didn't send anyone" and another, "One week it happened four times, one carer did not turn up". As a consequence of this, their mobility had been affected leaving them in unnecessary pain.

Staff told us, they were sometimes phoned on their days off to ask to cover vacant shifts, with one member of staff commenting, "You can't say no, they make you feel bad". Staff also told us they had sometimes had to support people without having the necessary clinical training. The manager told this had happened on occasions, when there had been insufficient staffing, but explained they had worked with the provider's specialist's nurses to try and ensure the person was being safely supported.

People told us they were not always informed of who would be arriving to support them with one person commenting, "Sometimes different people turn up" and another told us, "I am not kept informed when there are changes of time and carer". A further person told us that it had been as a result of our inspection, that they now received a care rota which they found useful.

Whilst some staff told us they had enough traveling time, some staff told us they did not, comments included, "When you are driving you are so stressed", "No. Once I get there in the morning I will tell the client I am going to be late tomorrow", "Generally speaking, but not always. I am late for some visits, but most of the clients understand if I explain" and, "Not always. It means we fall later behind and finish later". One person told us, "Staff, tell me that they are very short staffed. They are not allowed travelling time so I let them leave early, they are under severe strain, it's not right that they have to do so much". Another person told us, "Their time keeping is dreadful, they can't keep to the original agreement". Staff told us it did not help how regularly their rota changed, with one member of staff told us, "It's ridiculous, I've had four rotas in a day, it's constantly changing".

The manager recognised people had experienced staffing problems, and explained the main reason for this, had been because of a result of managerial changes, which had resulted in a lack of organisation within the service. The manager was also aware of how staff, were currently feeling and was talking action to make improvements and improve staff morale by holding staff meetings, and having one to one discussions. The operations manager told us a staffing analysis was being carried out to look at how staff, were deployed within the service. Staff told us since the recruitment of the new manager, they felt confident changes would be made and improvements seen for them, and for people using the service.

People's risks associated with their care were known by staff, such as how people needed to be moved by the use of moving and handling equipment. However, people did not always have risk assessments in place relating to health risks. For example, one person had epilepsy and one person was diabetes and whilst staff received first aid training, there was no detail in their care plans about what signs to look out for prior to them becoming ill. This meant people may not be supported safely and/or with continuity. One person suffered with frequent urinary tract infections (UTIs) however, their care plan did not detail the importance of staff encouraging drinks.

Risks associated with people's care were not always recorded. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had environmental risk assessments in place, which detailed any risks to staff, such as pets, trip hazards or poor outside lighting.

There was an out of hour's number for people and staff to call in an emergency. People and staff were positive about the response they received from this team. There was a lone working policy in place to help mitigate the associated risks which can arise from lone working, but some staff told us they did not know about the policy and/or how it affected them. This meant staff could be at risk when working in isolation, because they may not know what action to take in situations which they may feel vulnerable in. People told us they felt safe when staff entered their home, with one person telling us "They are very trustworthy". Staff, were supplied with a uniform and an identification badge so they were recognisable. People who had a 'key safe' had their details held securely.

People were protected from abuse. Staff had undertaken regular safeguarding training and knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff, were confident action would be taken if they reported their concerns to the manager. The provider had a safeguarding policy in place which staff could refer to, but did not make reference to the local authorities of which the service worked within. This meant staff may not have immediate access to the contact details they need. The operations manager told us this would be updated. Staff had been recruited safely to ensure they were safe to work with vulnerable people.

Where staff, were responsible for people's medicines, these were managed safely. People had care plans in place to provide staff with details about how people should be supported, and staff had undertaken regular training to ensure ongoing competent practice.

Overall, people were protected by infection control procedures to help reduce the spread of infections. People told us staff wore gloves and aprons when providing personal care. Staff had undertaken training and told us there was always a good supply of personal protective equipment (PPE) commenting, "It's always available if I want to go to the office to pick some up. It's no problem".

The provider learnt when things went wrong, in order to improve the service. The provider had been receptive to previous inspection feedback regarding the service, and had created a service improvement plan. This plan was being used to help develop the service.

Good

Is the service effective?

Our findings

People told us staff had the right skills to meet their needs, with one relative commenting, "They shower and dress him, they cream his legs, especially his knees. Yes I would say they know what they're doing, they're a nice crowd of carers". However, despite the provider having a comprehensive induction programme, two members of staff told us that they had to 'learn on the job'. With one of these members of staff having never worked in the health and social care sector before. The manager told us this was not how the induction process should work, and explained this would be looked into.

Staff had undertaken training the provider's 'mandatory' training which included moving and handling, infection control and first aid. Staff, who supported people with clinical needs, received healthcare training in topics such as spinal care, tracheostomy care and percutaneous endoscopic gastrostomy feeding (PEG). Staffs ongoing clinical competency was assessed by specialist nurses, employed by the provider. Staff, were complimentary of the training they received, but told us they had not received supervision of their practice for some time. The manager recognised this and already had a plan in place to rectify this.

People's health and social care needs were assessed to help ensure their needs were met, one person told us and, "My husband has complex problems which may vary from day to day. His needs have to be reassessed each time the carer visits and then the carer adapts to meet those needs". People received a pre-assessment of their care, prior to using the service. This helped to ensure the service could meet the person's needs.

People were supported with their consent to obtain help from external professionals if their care needs were changing. Staff told us, how they would support people to contact their GP or district nurse. One member of staff told us, "We have the most amazing respectful relationship with external professionals".

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. 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's human rights were protected. People were assessed in line with the MCA to check their ability to consent to their own care and treatment. People's care plans provided detail about their mental capacity and how this impacted on the decisions they made, for example choosing clothes. The manager and staff had a basic understanding of the legislative framework.

People's individual communication needs were known by staff, and staff described how they adapted their approach to each person. People's care plans supported staff to meet people's individual needs, with one person's care plan describing how too much background noise could distort one person's hearing, so staff were asked to limit noise, to help ensure effective communication. However, one person who was unable to read had not been provided with a care plan in a suitable format. This demonstrated the provider had not

fully considered the Accessible Information Standard (AIS). The AIS is a national requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

We recommend the provider takes account of the Accessible Information Standard (AIS) and uses it to help improve the service.

When required, people were effectively supported with their nutrition and hydration. People's likes and dislikes had been recorded and people told us staff listened to what they wanted, and accommodated there requests. One person told us, "My husband cannot swallow so the carer has to help prepare thickened shakes and help to feed him. Luckily he can accept water and the carer notes his entire fluid intake to ensure he is properly hydrated".

Requires Improvement

Is the service caring?

Our findings

Overall people's privacy and dignity was respected, people told us "They are all very respectful", "Staff protect my privacy and dignity", "They respect me" and, "The carer makes sure his privacy is protected and he is dressed properly afterwards. We sometimes have visitors in the house and the carer knows who she can discuss things with and when to be discreet". Staff explained how they promoted people's privacy and dignity, by closing curtains and shutting doors. Staff also told us how they put themselves in the person's position, thought how they would want to be supported, how embarrassed they may feel, and what would make this better. For example, by covering up parts of a person's body when supporting them with personal care. However, one person told us that staff did not always do this, and had at times, called out for staff to return to the room to cover them up.

One person told us, "They never tell me about when they're going to train someone else, it would be nice if they could show some respect and call me and let me know, they just turn up with another carer. They went onto explain, that they are never offered a choice, and if they were offered a choice, they would prefer not to participate in this.

People were supported to be part of decisions relating to their care. Checks of people's care helped to ensure people were satisfied with how they were being supported. However, people's views were not always respected or listened to. For example, one person had requested gender specific care staff, however they told us this did not always occur. Two people told us how they preferred staff not to wear their uniform, because they did not want their neighbours knowing they received care, and did not want to feel like they were in a hospital. However, they explained this did not always happen, with one person commenting "I would prefer it if they didn't". These requests had also not been documented in their care plans.

People told us, staff were kind commenting, "I have the highest respect for these carers, they're very good, I have no worries or concerns about them at all", "They always sit down, and we have a chat and a cup of tea", "They are kind, compassionate" and, "The carers are kind to me, they help me to choose what to wear and what to have for breakfast".

Staff spoke fondly of the people they supported and displayed passion for their job. One member of staff told us how they had flexibly changed their visit time to enable one person to enjoy a lie in, another told us how they had gone out in the snow to make sure people got their newspapers. One member of staff told us, "I try to ensure they are not left in a state of discomfort, or lacking anything, when we leave the house. To make them feel cared for".

Staff had received training in the Human Rights Act 1988 and explained how they supported people in the same compassionate way, regardless of their gender, sexuality or ethnicity.

People's independence was promoted, staff told us how they encouraged people to do as much for themselves as possible commenting, "Not immediately rush in and doing it for them. Having the patience to let them try to do it for themselves. Encouragement to try things by themselves" and, "I try to keep her a bit

mobile in the house, take her into the garden, encourage her to use her frame so she can go outside". One person commented, "They encourage my independence", and a relative explained, "They seem to be encouraging her independence".

Requires Improvement

Is the service responsive?

Our findings

Overall, people had a care plan which had been written with their involvement. . People's care plans detailed information for staff to help ensure people received the care they needed and wanted. However, for one person we visited, who required support with their moving and handling and clinical care needs, they did not. Following our attendance, the manager made a visit to the person's property but could also not find it. We requested a care plan was put into place within 48 hours, which occurred.

People's care plans were reviewed with people, however one person told us how parts of their care had not been discussed with them, and there were aspects they would have liked further support with. We spoke with manager about this, who promptly arranged to visit the person to carry out a new care plan review.

Staff told us, people's care plans were not always up to date and reflective of people's care needs, with one member of staff telling us of a care plan which had not been updated in a few years. They also told us they did not always read people's care plans, because they did not always have time. One member of staff told us, "It depends it they have a care plan", "Usually we have a care plan and it's there to look through to find out what to do" and, "In seven months, I've only managed to read a handful. You don't have time to read the care plan".

The manager told us they were aware that action was needed to bring care plans up to a better standard. Action had already commenced to audit files to create action plans, which would help to make the necessary improvements. The recruitment of new supervisory staff would also support this process.

Overall, people's concerns and complaints were listened to. People, told us they knew who to contact to complain, commenting, "I am not a complainer, but I would phone Allied if I had a concern or tell my daughters, and they would complain for me", "If I had a complaint or concern I would phone the office, I don't like to complain too much because of the pressure they are under". However, some people told us when they contacted the office they did not always get a response to their concern, with one person telling us "I phoned them up to ask them if I can have a later visit. They don't always get back to me, or tell me if they have sorted it out. That's not just a one off, it's happened quite a bit". Another person told us, "There's no point calling the office, they don't do anything, they say they're doing something about it, but they don't and they never call back" and, "Complaints have been made to the company but there has not been an outcome from the complaint, often telephone calls are not replied to".

The manager recognised that, people's complaints had not been monitored and handled well. They explained, "We are never going to repair the damage that has been done, but we can move forward". The provider's complaints process had been re-implemented to help record complaints effectively, help ensure successful outcomes for people and to monitor trends and themes. As a result of a quality assurance visit by the local authority, the manager had sent the complaints policy out to people who used the service in Cornwall, and would be doing this for others also.

Requires Improvement

Is the service well-led?

Our findings

Allied Healthcare Plymouth is a domiciliary care agency. It provides personal care to people living in their own homes. It currently provides a service to children, younger and older adults who need support with their personal care and/or have complex clinical healthcare needs. The service supports people within the localities of Cornwall, Plymouth, Barnstaple and Exeter. The service is owned by Nestor Primecare Services Limited, who have 83 branches across the UK.

Before our inspection, the provider had already recognised improvements were required, so as a result had made changes to the structure of the organisation, by registering the service in Plymouth, and had recruited a new manager. The new manager had applied to the Commission to become the 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.

The new manager was being supported by the operations manager, and weekly meetings were held with the operations manager to discuss the compliance and financial accounts. Whilst the new manager told us they felt supported, they had not received a formal management induction into the organisation. This meant the manager may not be aware of essential policy and procedures pertaining to the day to day management of the organisation.

There was a comprehensive programme of monitoring audits which the operations manager had responsibility for their oversight. The audits formed part of the providers overall governance policy. These included random sampling of people's care plans, and recruitment files. In addition, there were checks pertaining to the office environment. However, whilst these checks were in place, they had failed to identify the areas which were found to require improvement, as part of this inspecting. For example, risks associated with people's care not always being documented, suitable staffing provision not always in place, the promotion of people's privacy and dignity, people's complaints not always being listened to and the culture of the service.

Whilst staff recognised how busy senior managers were, some staff told us they did not feel supported by the operations manager because phone calls were not always answered and/or emails responded to. This resulted in staff telling us they feeling isolated.

Staff also told us, they felt they worked for the 'branch' and did not feel part of the bigger organisation, because of a lack of communication by senior management. One member of staff told us, "I wouldn't recommend anyone joins this 'company' but if things improve, I would recommend somebody to work for the 'branch'. Another commented, "I don't have a high opinion of this company. I have a high opinion of the staff around me, people and local level management" and, "They seem to not care". The provider's vision statement was, "To be the choice for care that give people the freedom to stay in their own homes". However staff, were not aware of this statement, which demonstrated staff lack of engagement with the

wider organisation. Despite an employee recognition scheme, staff did not feel their contribution was valued.

The failings identified as part of this inspection demonstrated that the provider did not ensure that continuous learning took place to facilitate improvement. However, the manager attended a weekly meeting to discuss the provider's ongoing improvement plan, making sure it was being completed and starting to have an impact on the overall quality of the service.

Staff, were complimentary of the new manager, and of their kindness and passion, with one member of staff commenting, "Hopefully we have turned a corner and going forward. I think the manager, seems to be competent, confident and knows where she wants to get the company".

The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care people received was not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager was making steps to improve the culture. There was a staff feedback box in the office where staff, were able to complete forms which asked them for their views such as "Do you feel listened to", "Do you feel happy within your role" and, "If you could change one thing what would it be"? One member of staff told us, "I think it is getting better, and staff morale is improving, but that is down to local level staff, not corporately".

People, staff and the public were involved in the ongoing development of the service. Surveys were sent to people to obtain their views, and feedback was collated. At the time of our inspection, no recent survey had been carried out, but plans were in place to carry one out.

There was a confidential safeguarding and whistleblowing line which staff could use to raise concerns and whilst staff told us they would feel confident about raising concerns, they had failed to raise concerns about the culture of the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks associated with service user's care were not always recorded.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care people received was not effective.