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Princess Homecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the comprehensive inspection of this service in November and December 2015 we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safe care and treatment of people, the management of medicines, a lack of a clear pricing policy, adhering to the principles of the Mental Capacity Act 2005, record keeping, safe recruitment practices, staff training and supervision and how the service was managed. We issued the provider with a notice to cancel the provider registration stating they must take action. We shared our concerns with the local authority safeguarding and commissioning teams.

We carried out a comprehensive inspection on 29 September and 5 October 2016, to assess whether the provider had taken action regarding the breaches we found of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014, and to provide an overall quality rating for the service.

The registered provider had made significant improvements around the safety of people's care and treatment. People and families told us they felt safe with the staff who delivered care and in the way care was given. All staff had received training in the management of medicines and behaviour which may challenge. Staff told us this training had been valuable.

Risk assessments relating to people's care and treatment had been rewritten and for the most part gave clearer guidance on how to minimise potential risks. However, further development of risk assessments was required. There was a lack of detailed information when recording incidents.

A more robust pricing and invoicing system was in place which assured people of clearer and more accurate billing.

At this inspection we found the provider had made important improvements in their management of medicines. However, improvements were still required in the accurate recording of medicines and more robust auditing of medicines.

The system for staff training and supervision had been updated and staff received training relevant to their role. All staff including the registered provider and deputy manager received on-going support through supervision. Regular team meetings were held and staff told us they felt supported by the management team.

With the exception of one person, where people's capacity to consent to specific decisions was in question, a mental capacity assessment had been completed. This was in relation to taking their medicine, the use of some types of equipment which may act as a restraint, consenting to their care and treatment and sharing their information with other agencies. Mental Capacity assessments were now reviewed as part of the care review process or when people's circumstances changed.

The registered provider told us that some people had arrangements in place for their nutritional and hydration needs to be met as part of the provision of care and treatment. Within people's care plan there was information as to people's likes and dislikes regarding food and any special dietary requirements. The guidance in place for eating and drinking was not always being followed or potential risks identified.

People received support from health and social care professionals and the registered provider ensured relevant information was shared with staff.

People and their families told us staff were kind, caring and respectful. Staff knew people well and their preferences for the way they wished their care to be delivered. Care records were person centred as they reflected in detail the wishes of the person. The tone and language used in the recording of people's care was appropriate and the service continued to monitor this.

Care records were person centred and described in detail people's care routines and their preferences. However, some records such as risk assessments and management plans were unclear and further improvements were required.

Information was available to people about local activities and clubs where they could socialise and meet new people.

The provider's website and information leaflet had been updated to reflect accurate information about the service. All of the provider's policies and procedures had been revised. Working practices were being monitored and staff were involved in the future development of the service.

A new addition to the management of the service was a quality assurance manager. The deputy manager and the quality assurance manager had been integral to the changes which the service had made and were working on embedding these improvements. The registered provider told us there was now a clear vision of where the service was going and its future development. One aspect of this was changes which were going to be made organisationally and to the management structure of the service.

In October 2015 the overall rating for this service was 'Inadequate' and the service was therefore in 'Special Measures'. Following the inspection carried out in September and October 2016 we have changed the rating to overall 'Requires Improvement'. The service is therefore no longer in special measures. You can read the report from this inspection by selecting the 'all report' link for Princess Homecare on our website at www.cqc.org.uk.

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 fully safe.

People told us they felt with the staff who supported them and in the way their care was delivered.

People told us they received their medicines as prescribed by their GP. The provider had made improvements in their management of medicines. However, improvements were still required in the accurate recording of medicines and to fully establish more robust auditing of medicines.

People and families told us they were happy with the way their care was invoiced by the service. The provider had made improvements to the system of billing and invoicing people for care.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff received support through supervision, training and regular staff meetings.

The registered provider worked with local health and social care agencies through making direct referrals on people's behalf.

With the exception of two occasions the registered provider worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People and families told us the care staff were kind, caring and friendly.

The registered provider had sought the views of people regarding their end of life care wishes.

People's dignity was protected because care was delivered in a

way which ensured people's privacy.

Is the service responsive?

Requires Improvement

The service was not fully responsive to people's care and support needs.

Care plan routines were detailed, person centred and documented how the person wished their care to be delivered.

Not all care records were complete. Some risk assessments were not in place or were not clear on how to mitigate risk.

People and families told us they knew how to make a complaint if they were not happy with the service.

Is the service well-led?

Requires Improvement

The service was not fully well led.

People were consulted about their views on the quality of service provided to them.

A plan of audits was in place and this was being implemented.

The deputy manager and quality assurance manager had made improvements across the service and the new systems and processes required embedding as the next step in their progress.

Princess Homecare

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.

We undertook the comprehensive inspection of Princess Homecare on the 29 September and 5 October 2016. We gave the provider 48 hours' notice of the inspection to ensure the relevant people would be available. We inspected the service against each of the five questions we ask about services: is the service safe, effective, caring, responsive and well led? This was because the service was not meeting the legal requirements in relation to these questions.

The inspection was carried out by two inspectors. Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet the legal requirements.

During our inspection we spoke with the registered provider, deputy manager, a quality assurance manager and two care staff. Following the inspection we spoke with two relatives of people who use the service and one person who used the service. We received feedback about the service from two health and social care professionals.

We reviewed a range of records and systems which included care records, financial processes, quality monitoring and audits, staff files including training and supervision records, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At a comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to protect people from potential abuse and improper treatment and failed to take action, when aware of potential abuse. There was a lack of transparency over how people were charged for the service they received. There was a lack of risk assessments in place as to how staff should manage and support people whose behaviour could be challenging. Risk assessments in place did not highlight all of the potential risks and did not contain information to mitigate them. Care staff had not received training around managing behaviour which challenges. The provider had not gained consent from people to display their names on the provider website. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 13 as described above.

At this inspection, all of the risk assessments in relation to people's care and treatment had been reviewed. Risk assessments for people were more detailed and gave clearer guidance on the potential risk and how to minimise the risk, such as in using equipment, pressure ulceration, nutrition, mobility and health and safety. However, for some risk assessments there was insufficient information about what the risks were and how staff should manage these. For example a 'challenging behaviour' risk assessment for one person stated the reason for the plan was because the person could become 'moderately agitated', but did not state what this meant for the person and how it impacted on others. The scoring tool used to determine the level of risk such as 'implement communication strategies', 'implement environmental strategies' and 'observation' were unclear as to what these meant and how the risk would be managed.

Another person was identified at risk of aspiration following a speech and language therapy assessment. A list of suggested foods to eat had been provided by the health care professional. The person chose to continue to eat certain foods which would increase the risk of choking. However, there was no risk assessment in place for the choices the person was making and the potential risks to them. We refer to risk assessments further under the responsive domain.

There was a lack of information recorded for one person in order to put preventative strategies in place to minimise the occurrence of falls. The recording in place did not gather enough information to be able to sufficiently investigate why the falls were occurring and how they could be minimised in the future. This was because the records lacked details about the times of the falls, how the person was found or what they were doing at the time of the incident.

Staff had received training in supporting people whose behaviour may challenge. Staff told us they felt this training was valuable and gave them confidence to be able to support people in a positive way. Daily records evidenced that people were being appropriately supported and according to their wishes. Care staff met with the management team on a regular basis to discuss people's needs. This ensured that staff received on-going support and the provider was aware of any potential changes in people's care needs. The

provider had made improvements in their understanding of safeguarding, their systems and the way they worked. However, improvements were still required to ensure people were protected from the potential of abuse through more robust assessment of risk and incorporating this into the care planning process.

The provider had reviewed and revised their financial systems. Improvements had been made to ensure the process of charging and invoicing was more transparent and consistent. There was now a price list which stated the standard charges for services and people were being invoiced in line with this. This meant people could be assured of a more consistent fee structure.

People told us they were happy with the way their invoices were managed and the system for making payments. The invoices people received were more detailed and better identified the service which people had received and were being charged for. However, daily travel costs for staff to attend appointments were included with the daily cost of personal care. This did not enable people to easily identify what they were paying for. The deputy manager told us they would address this immediately and during the inspection changed the invoice template so these entries were separated and then a total charge for the service was given.

There were now additional checks in place to ensure that invoices were correct and reflected the actual service people had received. We found no errors in the invoices we reviewed other than where the person had not been charged enough and a discrepancy for another person where the hours of care provided did not match the invoice. The hours charged for all other invoices corresponded to the provider price list in place. The deputy manager explained they continued to improve upon their system for processing invoices. For example, invoices were currently sent out on a weekly basis, however this did not always allow them sufficient time to collate the weekly returns for the hour's people had received care. They told us they would be moving towards a monthly system of billing but would accommodate people who still wished their invoices to be sent weekly.

The contracts for people's care and treatment had been revised. A copy of the most recent was held in the person's care records with most of the out of date contracts having been archived. We reviewed the daily records which listed the number of hours people had received a service. These tallied with the invoicing for the billing period. However, the contracts did not specify the agreed number of hours, the time or days that care had been contracted for and the number of staff required. This did not enable a clear audit trail between the assessment of need, the contract, daily record of care delivered and the invoicing. For example, one contract had been updated to reflect a new contract date but there was no evidence in the care records of a change in the person's care needs.

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure that care and treatment was provided in a safe way for people through the proper and safe management of medicines. Not all staff had received training in the administration of medicine, there was a lack of information to inform staff how they supported people with their medicines and no audits had been carried out to check medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 12 described above.

Families told us they thought the care staff had the right skills and knowledge to manage medicines safely. They told us their loved ones received their medicines on time and care staff checked the person was not in pain. Staff told us they had received training in the administration of medicines and training records confirmed this. They were able to explain to us the different medicines people took and the reasons why

they had been prescribed. The Medicine Administration Records [MAR] sheets had been amended to give the time frame in which the medicines should be administered to the person (Morning, Lunch, and Evening). Staff administered pain patches to some people and records documented where the patches had been applied to in line with the manufacturer instructions. However, within the records we found that some application entries were missing. It was therefore unclear if the patch had been applied as prescribed.

People kept the supply of medicines in their own home and families would order and collect the medicines from the pharmacy unless agreed they required Princess Homecare to undertake this service. Each person had a medication risk assessment in place, although where one person was refusing to take their medicine there was no assessment in place around the potential impact of this.

Information was in place to inform staff how they should support people with their PRN medicines. [PRN is where people have a medicine which they take as and when required]. We found for the most part that more robust recording was being carried out when PRN was administered, however there were some omissions. For example, on one record there was no information about the variable dose of the paracetamol the person took.

There were some anomalies in the way information was recorded. The PRN medicine administration record detailed the date and time of topical cream applications or medicine administration but not the reason for giving it. Staff completed a daily record of what care had been given that day. Codes were used to state the type of intervention given. However these codes were not included in the code for medicines or creams. This did not give a clear record of the medicines or creams administered.

The provider was auditing the medicines people took, their stock levels and disposal of medicines. Following the inspection the provider submitted a more robust auditing plan for their medicines which they had implemented and would monitor for effectiveness. Information was available to staff on the side effects of medicines and how staff should recognise and respond to this. The provider had made improvements in their management of medicines. However, improvements were still required in the accurate recording of medicines and to fully establish more robust auditing of medicines.

The provider had updated their website and removed all reference to individual people who use the service. A clear system was in place to gain consent to share information and the provider Data Protection Policy had been updated to reflect this.

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure people were protected from the potential of harm as not all staff had received training in the safeguarding of vulnerable adults. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 18 described above.

At this inspection we spoke with two care staff about safeguarding the people they cared for. They were able to identify all the types of potential abuse and who they would report suspected abuse to. Staff confirmed they had received refresher training in the safeguarding of vulnerable adults. They said this topic was discussed during team meetings and within staff supervision. Staff told us "I would report something I did not think was right straight away". The provider held regular team meetings with staff where the revised safeguarding policies and procedures were discussed.

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the

registered provider had failed to ensure safe recruitment practices were followed. The provider had not assessed all of the potential risks associated with the recruitment of staff. This was a breach of Regulation 19 of the Care Quality Commission (Registration) Regulations 2009 (Schedule 3). As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 19 as given above.

The provider told us they had learnt from their previous actions and future recruitment would be more robust and in line with their revised policies and procedures. Since our inspection in November 2015 there had been no new staff recruited. The policies around the safe recruitment of staff had been revised.

People and their families told us they felt safe with the staff that supported them and the way in which they were supported. Comments included "They are lovely, I feel very safe, no problems" and "Yes, I do feel safe and they always check things are locked up before they leave". Staff wore identity badges and had access to a key safe to obtain entry to the person's home. A healthcare professional told us they had visited a person with a member of the care team and stated they [the care worker] called out and made sure the person was aware of who was entering their home.

When supporting people in their home, staff had access to the appropriate personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. Following the inspection the provider supplied us with an infection control audit plan which they had implemented.

When people began to use the service or if requested, the provider gave people information about local authority funding for care and the eligibility criteria. Recently the provider had introduced a check to be made at each review to ensure people were aware of this information. This would enable people and their family to review if they now met the criteria for local authority funding.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure that mental capacity assessments had been undertaken to determine if people had the capacity to consent to their care and treatment. The provider had not done everything which was
practicable to help the person make a decision for themselves before concluding that they lacked the capacity to make the decision. In addition, decisions relating to people's health and welfare were being made on people's behalf where the person making the decision did not have the legal authority to do. Not all staff had received training in the MCA and were not confident in explaining how the MCA related to the people they cared for.

As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as described above.

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 MCA 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 accordance with the principles under the MCA.

During this inspection we found the provider had put into place a more robust system of implementing the requirements of the Mental Capacity Act. This was with the exception of one person who was refusing appropriate care and treatment and this was impacting upon their well-being. A capacity assessment had not been undertaken to ascertain if the person understood the impact of their actions upon their health. This would have signposted the provider to raising this as a concern with the relevant health and social care agencies.

For all other people where their capacity to consent to specific decisions was in question, a mental capacity assessment had been completed. This was in relation to taking their medicine, the use of some types of equipment which may act as a restraint, consenting to their care and treatment and sharing their information with other agencies. Mental Capacity assessments were now reviewed as part of the care review process or when people's circumstances changed.

The assessment of capacity documented ways the service had sought to involve the person in understanding the decision being made. When people were deemed not to have the capacity to understand the impact then a best interest meeting was held. These meetings included the person, their family and any other health and social care professionals involved.

Where people had chosen a Legal Power of Attorney to make decisions about their finances or health and welfare, the care records held information about the LPA registration in place. This ensured the provider had

information which validated the person holding the LPA to make decisions on the person's behalf. However, for one person who was no longer receiving a service from the provider, a request was made from a family friend for emergency cover. The service was aware the family friend did not have the authority to make such a request as the local authority held this responsibility. The provider did not contact the local authority and subsequently provided a short-term service to the person. The deputy manager told us "We agreed to provide this cover because we were worried the person would not receive appropriate care. This was done with the best intentions, however, we now realise this should have been passed to the local authority and in the future we will not hesitate to do this".

All staff had received refresher training the MCA. We spoke with two care workers who were able to confidently discuss the MCA and their role in ensuring people's rights were upheld. Staff described how they enabled people to make day to day decisions about their care and support and care records clearly documented how staff supported people to make choices and decisions about their care.

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure one person's human rights were upheld. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to the requirements of Regulation 10 as given above.

At the time of this inspection there were no people receiving care where a surveillance camera had been installed with or without their consent. The registered provider told us should this situation arise again they would immediately pass this to the relevant safeguarding team. The management team stated all staff had completed further training around protecting people's rights and had a clearer understanding around the use of a camera in a person's home. The relevant provider policies had been updated to give clearer information about the use of covert camera's and what steps the provider should take to protect people's human rights.

During the previous inspection in November 2015 we found the method of staff training was not fully effective and training courses had not been prioritised according to the immediate skills staff would require upon starting their employment. In addition, not all staff had received training to meet the needs of people they supported, the provider training matrix was not complete and the training policy did not state the timeframe in which courses should be refreshed.

Whilst staff were able to contact the registered manager on a day to day basis, not all staff had received formal one to one meetings in a timely manner. The provider's supervision policy did not give a timescale for the frequency of staff supervision. For the deputy manager, there was no evidence that supervision had taken place. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 18 as described above.

During this inspection we found the provider had addressed the concerns we had identified. The methods used for staff training included electronic based, face to face training, using practical scenarios, discussion at team meetings and through written work. Staff told us they had benefitted from this change as it better suited their preferred way of learning. A member of staff told us "we did manual handling training and used the hoist on each other. It really did put across how other people must feel when we use this type of equipment; it was so useful to have that insight". The quality assurance manager told us they assessed the staff understanding of their learning through discussion at team meetings and through the supervision

process.

Staff told us "It's been good to have our training prioritised, it's been really good, we go through things together" and "The training has been very interesting and helpful".

The provider 'Training Policy' had been revised and stated what training courses were a priority when new staff began working at Princess Homecare. For example, the Safeguarding of Vulnerable Adults, the MCA, Infection Control and Manual Handling. There was a timescale given for when staff must complete the training by. This ensured that new staff were appropriately skilled to be able to support people effectively and safely. At the time of this inspection, no new staff had joined the service.

A revised training matrix was in place which documented the courses staff had undertaken, the date of the course and the date of refresher courses. Staff had received training which was relevant to their role and the needs of people they supported. For example, Understanding Dementia, Dealing with Challenging Behaviour, Medicines training and Record Keeping. The deputy manager audited that staff training was being completed. Discussions were held in team meetings as to other relevant training courses which would support care staff in their role to meet people's changing needs.

All staff had received training in first aid. In addition, a 'Paramedic application' had been put onto the mobile telephone of each member of care staff. The application gave staff instant guidance on any questions they may have around responding to accidents, such as burns. The quality assurance manager told us this was another way they could be more pro-active in keeping people safe.

Staff told us they received supervision every six weeks and the deputy manager and provider were meeting monthly with a consultant. Records confirmed staff were receiving support through supervision, team meetings and training. Staff told us during supervision, their progress was reviewed and they were able to raise any issues. The registered provider's supervision policy gave a timescale for the frequency of staff supervision including the management team.

The registered provider told us that some people had arrangements in place for their nutritional and hydration needs to be met as part of the provision of care and treatment. Within people's care plan there was information as to people's likes and dislikes regarding food and any special dietary requirements. Staff were able to describe people's dietary needs and how they supported them to maintain good nutritional and fluid intake, such as preparing soft foods, finger foods or ensuring that one person had a straw to help them to drink fluids.

People received support from health and social care professionals. One health care professional told us the registered provider was proactive in making referrals to health services on behalf of people. The provider had contacted one person's GP because they were not satisfied with the outcome of their response. They then contacted other specialists until an assessment was carried out and the person was then able to receive the health care they required. The health care professional told us the registered provider had been key in liaising with the health professionals for the admission of one person to hospital.

Another healthcare professional told us they were involved with the provider through offering occupational therapy services to people in their homes. They had found the staff's approach was friendly and respectful and felt staff knew the person and communicated with them well. They observed that moving and handling was carried out in a mindful way and commented "Carers always come across as caring and concerned for the welfare of people".

The registered provider held information about local advocacy services and this was available to people.

Good

Is the service caring?

Our findings

At a comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure that their record keeping policy was being adhered to by staff. Records held about people's care and treatment was not written in a respectful way and subjective language had been used. Some records did not give an accurate picture of the care given. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 10 as described above.

At this inspection we found the provider had made improvements to the tone, language and content of the recording of people's care and treatment. We spoke with one person who used the service. They told us "Staff are lovely and very respectful. No complaints at all". Families told us they were very happy with the care and support which care staff gave. They told us staff were patient, kind and caring and were 'always' respectful towards their loved one.

Staff completed records of the care and support people received each day. We reviewed the daily notes for six people who currently used the service. Staff had received training in record keeping since the inspection in November 2015. Apart from two entries, we found the language used to describe people's care was appropriate and factual. The daily recording demonstrated the caring nature and approach of staff from recognising the person may be in pain and how staff responded to this, to mention of how the person was feeling that day. The deputy manager audited the content of daily records and highlighted to staff any written statements which were not descriptive or clear.

The quality assurance manager had introduced a 'Record Keeping' card and all staff had a copy of this. This gave staff information on spelling commonly mis-spelt words, descriptions of appropriate words to use regarding emotions and wellbeing, and other hints and tips.

A one page document had been introduced into people's care planning. This document was person centred and clearly described what was important to the person, a brief history of their life and how best to support the person in the way they wished. It also highlighted people's likes and dislikes, such as their preferences for a particular gender of care worker.

People and their families told us the staff were respectful and provided care in a dignified and caring way. The care plans were mindful of people's dignity and privacy, for example for one person their care plan instructed 'Carer to leave the room whilst X uses the commode'. A member of staff told us "We treat every person with respect and listen to how they want things done". One person told us "They know my ways and care for me the way I have asked them to". One family member told us "Staff seem knowledgeable, only have to ask and they will give you guidance, they are so caring and very approachable". Another family member commented "They [Princess Homecare] involve the family and pass on any information they think we may need, they liaise with the GP and make sure our loved one is well cared for".

The registered provider had sought the views of people regarding their end of life care wishes. At this point, no-one had elected to give their views. The provider stated that some families had discussed this area with their loved one, but did not wish to formalise it in the care planning process. Some people had completed a Treatment and Escalation Plan with their GP and the registered provider was aware of their wishes.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Princess Homecare in November and December 2015, we found the registered provider had failed to ensure that care plans had been adequately developed to meet people's needs. Care plans were not person centred and daily recording was task focused. Risk assessments in place did not fully identify the potential risks people faced and did not correlate to the care plan. Terminology used in the recording of people's care was not descriptive. People's emotional wellbeing had not been monitored and inappropriate diagnosis was recorded without a formal assessment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to the requirements of Regulation 9 as given above.

During this inspection we found the provider had made improvements to the content, tone and level of detail in the care records. However, further improvements were required in monitoring that records were accurate, complete and actions identified had been followed up. Such as, a chart to monitor skin integrity did not contain information about the condition of the skin at each check, yet the risk assessment in place advised a 'change of linen' should the skin become moist. In the daily recording for one person it was noted their left arm was giving some discomfort and the instruction given was to 'monitor'. We found no evidence that monitoring took place as no further reference was made within the care records.

There were anomalies between risk assessments and support plans, for example a risk assessment for one person gave the level of risk of falls as 'medium' with the support plan stating the risk was 'low'. It was therefore unclear what the actual level of risk was and as a consequence what level of action should be taken to minimise the risk of falls. One person's care records had not been updated to reflect their current needs as the assessment for equipment stated the person was waiting for a gantry hoist. However, the hoist had been in use for some time.

Where a need had been identified, a risk assessment was not always in place. One person had been identified as having 'a swallowing constraint' in their communication assessment. No further information was given as to the impact this may have upon the person, for example when eating and drinking. An assessment for pressure ulceration had identified another person as being at risk. There was no information in this person's care plan other than asking the person if they wanted cream applied.

One person had undergone a speech and language assessment which recommended a pre-mashed and fork mashable diet. There was no reference to this recommendation in the care plan or of the potential risks to the person. For another person where their care plan stated with the breakfast routine 'right hand is not always good', it was unclear if they required support to eat or if staff required additional time to support with this.

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

Since the inspection in November and December 2015, the registered provider had introduced a new process for the initial assessment and care planning of people's needs. From the initial assessment, a plan of care was devised which informed the risk assessments required and subsequent management support plans. Each person had a one page profile which included a 'crisis' plan, such as new staff being introduced or hospital admission. Other information included 'What's important to me, my history and how best to support me'. Care records held information about people's likes and dislikes and their interests such as 'listening to organ music'.

We reviewed the care plans of six people which identified the level of support the person required at each visit. Care records were person centred and support plans were in place for pain management, skin integrity, continence, mobility and communication. For example, within one person's communication plan it was stated 'picking up colourful items shows X would like your attention'.

A pain management support plan identified how the person communicated with staff when they were in pain and stated 'being gentle with me supports my pain management'. For another person, their pain management plan identified the areas of the body which were most affected by pain and how this impacted upon the person. Risk assessments gave guidance to staff on how to minimise risk for example, an equipment risk assessment stated how the equipment should be used, what checks should be carried out and what to do in the event the equipment failed.

Care plans were detailed, person centred and documented how the person wished their care to be delivered. For example, 'X likes a rug over them and slippers on after personal care'. Other examples were information about items the person wanted to take to their day centre visit, the drinks and snacks to leave out for another person and leaving lights staff on for the person and the security of the building when leaving.

The language and tone used within the care records were appropriate with the exception of terminology used such as 'padded' to refer to supporting the person with their continence. We discussed this with the quality assurance manager who explained they continued to monitor and discuss appropriate terminology with staff. Clearer descriptions were given around people's emotional wellbeing.

The registered provider explained that for new people who used the service, their care plan would be reviewed after one month to ensure their needs were being met. We found care records were reviewed on a quarterly basis and a more comprehensive review carried out twice a year. Documents evidenced that people and their families were involved in this process and this was confirmed by relatives we contacted. When a care plan review had been completed, the date of the next review was documented and monitored to ensure the review took place.

At the end of each shift, staff recorded information which the next staff member should be made aware of. In addition, the office kept a communication book which detailed any visits by district nurses or the GP and actions staff must take as a result. Staff told us there had been a noticeable improvement in the information and guidance available to them.

The registered provider was mindful that some people might become socially isolated and as a result gave people information about local services, such as lunch clubs, social and friendship clubs, a local day centre and activities at the church in a neighbouring town. Should people require transport to attend activities, the registered provider offered transport at an agreed price.

The provider had a complaints policy in place and concerns raised were dealt with according to this policy.

A relative told us "I can raise any concerns I have with the carers or with the manager, they always listen". One person told us "They [the carers] are excellent, very nice indeed, I have no problems at all".

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Princess Homecare in November and December 2015, we found there was a lack of oversight in relation to the management of the service. The registered provider had failed to ensure that its policies and procedures were relevant to the service, accurate and were being adhered to. The standard of record keeping was poor. The provider website had not been maintained and promotional information was not accurate. The website contained logos from other agencies without their permission. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result we took enforcement action against the provider. The provider wrote to us with the action they were going to take to meet the shortfalls in relation to requirements of Regulation 17 as given above.

At the time of this inspection there were six people who were using the service. We spoke with the registered provider who had insight into the arrangements for each person and their current care needs.

We reviewed the provider's policies and procedures. Each one had been updated, was accurate and was relevant to Princess Homecare and its ways of working, ethos and values. Staff had access to the new policies and procedures and during staff meetings the policies were reviewed and discussed by all staff. During staff training sessions, the policies and procedures were again reviewed to ensure staff were confident in understanding what was expected of them. The quality assurance manager explained this was an on-going process and during meetings staff were encouraged to contribute with ideas on how the policies were implemented.

Previously, we found the safeguarding risk assessments which were in place for people were difficult to read because the text was too small. This meant there was a risk that staff were not using the risk assessment for its intended purpose. The provider had reviewed all of the safeguarding risk assessments which were now more detailed about the potential of risks to people, and the text was now larger making it easier and clearer to read.

The provider's website had been updated and now contained accurate information relevant to the service provided. The logos of other agencies had been removed from the provider website. The provider told us they were more informed as to the steps they would need to take to gain permission to use logos not belonging to Princess Homecare. The information leaflet given to new people who enquire about the service had been amended to reflect that the delivery of personal care was to adults only, in line with the provider's registration with the CQC.

Records relating to people's care and treatment had been rewritten and presented a more person centred approach to their care. Each care record contained an index of the contents of the care file to enable the reader to ascertain if the records were complete. Care records were more detailed and gave clearer guidance to staff on the care and treatment to be delivered. Staff told us they felt the care records were 'a lot better and more detailed'.

Since the inspection in November and December 2015, the registered provider had employed an external consultant to support them in developing the service. The registered provider told us the changes in the systems and processes and the way of working had been very positive, but somewhat stressful. The registered manager and the deputy manager had received on-going support through management meetings and individual supervision with the consultant. The service had been reviewed by the provider and the consultant and an action plan put in place to work towards improving and developing the service further.

The external consultant was now employed as a quality assurance manager by the registered provider on a part time basis and were now an integral part of the team. They would continue to offer guidance and support around further development of the management team, staff and the service. The consultant was experienced within the domiciliary care setting and demonstrated to us a sound understanding of the fundamental standards of care. They had access to a range of expertise and resources to support the service to continue to develop and progress.

The registered provider told us there was now a clear vision of where the service was going and its future development. One aspect of this was the changes which were going to be made organisationally and to the management structure of the service. This would see another person (the current deputy manager) taking on the role of the registered manager and a change to the legal entity of the service.

The current registered provider would be stepping down from this and the registered provider role to focus on the care aspect of the service. They told us the support and guidance they had received from the consultant had been invaluable in enabling them to update their skills and knowledge. They had completed training at management level in leadership, supervision, record keeping, person centred planning and medicines.

The person intending to take on the registered manager role was the deputy manager. They were attending a regular meeting called 'the local network forum for registered managers'. They told us this had enabled them to make new contacts, share ideas, develop and learn. At a recent meeting they had suggested developing an online forum for registered manager's to have a platform to discuss ideas, outside of the quarterly network meeting. They had also started a 'Level 5 Diploma in Leadership of Adult Social Care' to give them the necessary level of skill to manage the service effectively. We found they were very enthusiastic and positive about their forthcoming role and particularly around continually improving and developing the service.

The deputy manager and quality assurance manager told us the service would be concentrating on embedding the new systems and processes.

For each person using the service, monitoring at an individual level took place. Such as, on-going review of their care records, medicines and accidents/incidents. Staff training and supervision was audited to ensure staff received timely supervision, to review the contents of the supervision and to link this with staff training.

Following this inspection, the provider supplied us with evidence of a scheduled auditing plan they had devised and which gave set criteria upon which to monitor the quality of the service. This enabled the service to have an overview of the quality of the service they provided and would include scheduled audits of medicines, infection control, care plans including the review of mental capacity assessments, incidents, staff training and its effectiveness, supervision and appraisals and feedback from people who use the service. They would also continue to review their service development plan.

The quality assurance manager explained some of the main changes they had made to the running of the service. Monthly management meetings were now held where plans for the continuing development of the service were discussed. This included a new software management system which would incorporate all aspects of record keeping including auditing. The service had signed up to the 'Social Institute of Clinical Excellence' website and were using the health and safety audit function which was reviewed at monthly management meetings. Staff were now undertaking specialisms and key roles such as a 'dementia' champion and a 'diabetes' champion. A member of staff told us "I am so excited about taking on this new role, I have completely embraced all of the changes, it's been so positive, continually improving ourselves".

During the inspection the registered provider showed us the result of a recent satisfaction survey of people who use the service and their families. Comments included, "Thank you for all you do", "Thank you for all you did for X, you have helped in many ways" and "We have been helped immeasurably, both with adapting to our loved one's changing needs and because staff are kind and gentle".

We spoke with families and one person who used the service, they commented "They [Princess Homecare] have helped me to stay at home, very happy with the care", "Very satisfied with the care my loved one receives, always willing to help and the carers are always on time" and "No improvements are needed, the care staff treat my loved one very well".

We spoke with staff who told us "I think we are now definitely going in the right direction. They [the management team] have always been supportive; it's a very supportive team. We have really pulled together and I think we can be really optimistic about the future" and "Both the registered manager and the deputy manager have been very supportive. We can always telephone the office if we need advice. I have worked here for many years and we give a very good quality of care. I couldn't work for a better service, I really enjoy my job".

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 Regulation 17 (1) (2) (b) (c) The registered provider had not ensured that systems which were in place effectively assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users through complete and accurate records.