MiHomecare Limited

MiHomecare Central London

Inspection report

Unit 2
Cambridge Court, 210 Shepherds Bush Road
London
W6 7NJ

Tel: 03331216801
Website: www.mihomecare.com

Date of inspection visit:
11 December 2017
12 December 2017
15 December 2017
18 December 2017

Date of publication:
07 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an inspection of MiHomecare Central London on 11, 12, 15 and 18 December 2017. This was our first inspection of the service since it registered with the Care Quality Commission. The service provides care and support to people living in their own homes. There were approximately 700 people using the service when we visited.

Prior to our inspection we received some information of concern from local authorities commissioning people's care. These concerns related to poor handling of complaints, safeguarding matters and service issues, poor quality of care records, ineffective quality monitoring, including missed and late visits and high staff turnover. We looked into these concerns during this inspection. The local authorities that commissioned the provider's services were working with them to support them to make improvements. The provider had deployed their head of quality and regional quality manager to lead on devising and delivering an improvement plan that had been created in consultation with local authorities. As a result of implementing this plan, the provider was in the process of completing a backlog of investigations in relation to safeguarding matters and complaints. The local authority had implemented a voluntary stay on further care packages until the provider had secured the required improvements to the service.

Safeguarding adults from abuse procedures were in place and care workers understood how to safeguard people they supported. Care workers had received safeguarding adults training and were able to explain the possible signs of abuse as well as the correct procedure to follow if they had concerns.

At the time of our inspection there was no registered manager at the service. 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 previous manager had left the service and a new manager had recently been appointed and was working at the service when we visited. They were in the process of submitting their application to be the registered manager to the CQC.

Risk assessments and support plans contained some information for staff, but we saw examples of incomplete records and therefore could not be assured that people were protected from avoidable harm. Care records also lacked information about people's health conditions and their mental health needs.

Care workers were provided with appropriate training to help them carry out their duties. However, there had been a delay in care workers receiving supervision and appraisals of their performance.

Complaints were not investigated and responded to in a timely manner. The provider had a system of audit to identify and manage quality performance issues and risks. However, due to the departure of several key staff members within a short period of time, these had not been appropriately managed for a period of approximately two months. The provider's systems for learning and making improvements when things

went wrong had not been effectively implemented due to these staffing issues.

There was an adequate system for administering medicines safely. Care workers recorded any medicines that were administered and these records were required to be audited by the care worker's supervisor on a monthly basis. Although there had been a delay in the return of these records to the office, the senior management team had conducted a recent in-depth review of records and taken action to rectify known issues.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. People's support plans included mental capacity assessments and where necessary recorded decisions in people's best interests in consultation with their relatives.

Staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way. Care records contained a good level of detail about people's individual needs and preferences.

People we spoke with told us they were involved in decisions about their care and how their needs were met. However, some people told us they were seen by different care workers and this had hindered their ability to develop a good relationship.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. However, care workers had not received regular supervisions and appraisals.

People were supported with their nutritional needs where this formed part of their package of care. Care records contained a good level of information about people's dietary needs.

The provider had a clear vision and credible strategy to make improvements and deliver high-quality care and support. The provider needed more time to implement this strategy in order to embed the required improvements. We saw evidence that feedback had been obtained by people using the service and the provider was working to deal with reported issues.

During this inspection we found breaches of regulations in relation to safe care and treatment and good governance. 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

The service was not consistently safe.

People's care plans and risk assessments did not contain a sufficient level of detail about how to mitigate known risks.

Procedures were in place to protect people from abuse. This included reporting and investigating concerns. However, the provider was experiencing a significant delay in the completion of their safeguarding investigations. Care workers knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

We found that recruitment processes helped to ensure that staff were suitable to work at the service.

The provider had a safe system for administering medicines to people.

Is the service effective?

Requires Improvement

The service was not always effective. People were not adequately supported with their healthcare needs. Care records contained very limited details about people's healthcare needs. People were supported with their nutritional needs where this formed part of the package of care required.

Staff received an induction and training. However, there had been a delay in conducting supervisions and appraisals of staff performance.

The service was meeting the requirements of the Mental Capacity Act (MCA) 2005. Care records contained details of people's capacity and where required, included written best interests decisions made on people's behalf in consultation with their family.

Is the service caring?

Requires Improvement

The service was not consistently caring. Some people were often seen by different care workers, hindering their ability to develop a relationship with their care worker. People gave good feedback

about their regular care workers.

As far as possible, the service supported people to express their views and be actively involved in making decisions. Care workers promoted people's independent living skills.

Care workers ensured people's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's complaints were not investigated and responded to in a timely manner.

People's needs and preferences were assessed before they began using the service. However care was not consistently planned in response to these needs or preferences.

People were encouraged to be active where this was part of the package of care required. Care records contained a good level of detail about people's recreational needs and how care staff could encourage these.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a comprehensive action plan in place which mirrored the issues we identified in this inspection, but the service had not had sufficient time to implement this.

Despite the pace of change which had occurred in the service, care workers told us they had confidence in the management team and felt comfortable approaching them.

MiHomecare Central London

Detailed findings

Background to this inspection

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

This inspection took place on 11, 12, 15 and 18 December 2017, and was undertaken by two adult social care inspectors on the first day, three inspectors on the second day and a single inspector on the third and fourth days. We were also assisted by two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience phoned people and their relatives to ask them their views of the service.

The inspection was announced. We gave the provider 48 hours' notice of our inspection as we wanted to be sure that someone would be available.

Prior to the inspection we reviewed the information we held about the service. This included statutory notifications received. A notification is information about important events which the service is required to send us by law. We also contacted staff members from local authority safeguarding teams for information about the service.

We spoke with 40 people using the service and four of their relatives. We spoke with 15 care workers after our visit over the telephone. We spoke with the manager of the service, the head and regional head of quality within the organisation who had been working at the service to secure improvements. We also spoke with the Chief Executive Officer of the organisation and liaised with key contacts from the local authorities commissioning care. We looked at a sample of 32 people's care records, 10 staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when using the service. People's comments included "I feel safe with the carers" and "I have the same carer... I trust her with my life." However, despite these positive comments, we found the provider had not always done all that was possible to protect people from harm.

Prior to our inspection we received concerns relating to the quality of care records. We identified some concerns about the quality of care records reviewed during our inspection. We looked at 32 people's support plans and risk assessments. A senior member of staff known as the field care supervisor visited the person using the service and conducted risk assessments on the safety of the person's home environment, their moving and handling needs, risk of falls, skin integrity and the risks associated with conducting household tasks such as cleaning and laundry. These details were accompanied by another document within people's care records known as the support plan which included information about people's required outcomes as well as a timetable for their care.

People's risk assessments included checklists which were filled in to determine what people's needs were, the level of risk involved and included a section for the field care supervisor to fill in to demonstrate what actions were required by the care worker to mitigate the known risks. We saw some examples of good written advice for workers in some of the risk assessments we saw. However, we also saw some examples of falls risk assessments that did not contain sufficient detail about what actions care workers were supposed to take. For example, we saw three falls risk assessments which stated that the people were at high risk of falls. However, there was no information recorded about how workers were expected to mitigate the risk or the circumstances in which the risk was highest.

We also found discrepancies in people's skin integrity risk assessments. We found the initial checklist within these risk assessments was completed. This included questions such as the current condition of the person's skin and whether they experienced any incontinence. However, we found that the subsequent section which involved stating what the level of risk was and the control measures needed to mitigate risk were either not filled in or very brief. Therefore we could not be assured that care workers had sufficient information about people's individual needs to ensure that they took appropriate action to protect people from developing pressure sores.

We spoke with the senior management team about some people's possible risk of falls and risk of developing a pressure ulcer. We were told that care workers had received training in these areas and would know that they were required to monitor people and report any changes to their supervisor. However, they agreed that risk assessments needed to be more robust and field care supervisors required further training in order to ensure this.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care workers about their knowledge of the risks of people falling and their skin integrity. They

demonstrated a good level of knowledge about what actions they were supposed to take in mitigating these risks. Care workers comments included "I have just seen a lady who has a high risk of falls. I make sure there are no obstructions on the floor and help her to move around", and "I have one client who has a risk of pressure sores although he doesn't have any at the moment. I do things like, apply a special cream and check his skin carefully when I'm giving personal care."

Staff received emergency training as part of their initial induction and this covered what to do in the event of an accident, incident or medical emergency. Care workers demonstrated a good level of knowledge about the type of risks people faced and demonstrated that they understood how to mitigate these. Care workers gave us examples of the types of risks people faced and how they responded to these. Their comments included "We know the risks our clients face from the care plan, but we also get to know our clients. I have one client whose moving has deteriorated and I have reported this to the office." Care workers told us they would contact the emergency services in the event of an accident or incident or take other appropriate action, such as informing the person's GP and their manager. Care records also contained detailed contingency plans in the event of a care worker being unable to attend to a person. These contained details of the person's level of need and whether their visit was time critical as well as the details of the agreed contingency plan that had been agreed with people.

The service did not always learn and make improvements when things went wrong. The service had a procedure on how to deal with accidents and incidents. This included reporting and investigating the matter and where appropriate, taking action to mitigate the risk of a reoccurrence. We requested the provider's accident and incident records. However, the head of quality was unable to locate recent records of accidents and incidents as well as subsequent actions plans. There were no reported accidents since February 2017. The regional head of quality and head of quality agreed this probably meant that accidents and incidents were not being reported as required and therefore agreed to retrain care workers in the process.

Prior to our inspection we received information of concern relating to the investigation and learning undertaken from safeguarding matters. We found the service had appropriate systems and processes in place to safeguard people from abuse. However, recent staffing changes had meant that these systems had not been properly implemented for a period of approximately two months. Safeguarding procedures included training staff, having a system of reporting concerns in place and conducting investigations of known risks. A number of staff previously responsible for conducting safeguarding investigations had recently left the service. This meant that for a period of approximately two months, there was a delay in safeguarding investigations being concluded. Immediate action had been taken to safeguard people from abuse, which included reporting concerns to the local authority and changing care workers where needed. However, due to the delay in the completion of investigations the provider was unable to analyse the outcome of safeguarding allegations and learn from these in a timely manner.

The above issues constitute a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People benefited from a service where staff understood their safeguarding responsibilities. The provider had a safeguarding adults policy and procedure in place. Care workers told us they received training in safeguarding adults as part of their initial induction and demonstrated a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place. This included using the providers whistle blowing policy. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. Care workers told us, "I have had concerns

in the past and I have reported them. It was handled properly" and another care worker told us, "I've never had any concerns, but I would report immediately to the office if I had any. I would never let anything bad happen to one of my clients."

The provider also had measures in place to minimise the risk of financial abuse. There were clear procedures in place and care staff were required to record the details of any financial transactions they had completed on people's behalf together with the receipts to evidence expenditure which were then reviewed by senior staff.

Prior to our inspection we received information of concern relating to how the provider monitored missed and late care visits. Some people also told us they had experienced missed and late visits in the past. We found the provider had experienced issues in effectively monitoring the attendance and timeliness of care workers, however they were taking steps to address this.

The provider had recently implemented an electronic monitoring system for the purpose of monitoring care visits. Prior to our inspection we found care workers compliance rate in the usage of this system was low at approximately 50%. This meant that the provider did not have accurate data to determine whether visits were missed or carried out late. Over a period of four weeks prior to our inspection, the provider had worked in conjunction with the local authority to improve the levels of compliance with the electronic monitoring system. The provider had contacted all care workers reminding them to log in when they visited people's homes. They had also commissioned a staff member to monitor the compliance rate on a daily basis. This staff member showed us the live data that she was using from the system to monitor care worker's movements and we overheard her conversations with care workers to check why they had not logged onto the system. As a result of the efforts made, at the time of our inspection the compliance rate with the electronic monitoring system was approximately 80%. The remaining 20% of visits were accounted for by the staff member who recorded the reasons for any missed visits and took action to replace any care workers who could not attend their scheduled visit.

We spoke with the head of quality about his interpretation of the data. He told us "We have been working really hard to ensure compliance with the system. However, 80% is an improvement, but still not good enough. We need to keep improving and will keep checking the data to do so."

We spoke with the regional quality manager about how they assessed staffing levels to provide care for people using the service. They explained that the initial needs assessment was used to consider the amount of support each person required. As a result the field care supervisor determined how many care workers were required per person and for how long. The regional quality manager told us that if as a result of their assessment more care workers were needed than requested by the referrer, this would be negotiated with the referrer who was usually the local authority. Care workers also confirmed that they kept the office informed about whether they needed more time to conduct their work. They told us the timings of their visits could be extended if this was required. One care worker commented "The times of my visits are ok, but I would report any issues if there were any."

The regional quality manager further explained that considerable disruption had been caused to the service as a result of staff changes within the office. This had resulted in disruptions to investigations and quality control systems which had necessitated the attendance of an improvement team who had devised and were in the process of implementing an improvement plan. At the time of our inspection we found all key members of staff had been recruited and had either started working for the service or were due to do so in the New Year.

The service followed safe recruitment practices and carried out recruitment checks to ensure staff were suitable before they started working with people. Staff files showed checks of employment histories, relevant written references, identification and criminal record checks. We looked at the recruitment records for 10 care workers and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms contained details of people's employment history.

The provider had a safe system in place to administer medicines to people, but this was not always being followed. People's care records included medicines risk assessments which concluded what level of support they required with their medicines. Care workers were responsible for administering medicines to some people and filled in medicines administration record (MAR) charts. Care staff made a note in people's daily records where they prompted them to take their medicines. Care staff were supposed to send MAR charts and daily records to the office on a monthly basis to be reviewed by a care coordinator who was supposed to query any discrepancies. However, the regional quality manager told us MAR charts were not being returned to the office as frequently as required and had not been monitored as expected due to the recent shortage in staffing numbers.

We saw some audits of MAR charts in the care records we reviewed. We saw that where these had identified errors in recording action was taken to address this which included providing further training to the care worker or supervising their practise for a period of time. We spoke with the regional quality manager about the monitoring of MAR chart audits. Whilst she agreed that these had not been done at a monthly rate as required, she confirmed that a number of audits had been completed since the introduction of the incoming quality team. As a direct result of monitoring of trends identified across the audits, an action plan had been implemented which involved a period of further training for all staff as well as updated written guidance. Care staff we spoke with told us they had received medicines administration training and records confirmed this.

The service protected people by taking action to prevent and control the spread of infection. People were asked about whether they were happy with the cleanliness of their home in regular monitoring calls and visits. Risk assessments were also conducted around cleaning and laundry tasks and these included some advice for care workers in how to maintain good levels of hygiene in people's homes. Training records also showed care staff received training on infection control and food hygiene matters. When we spoke with staff they were clear about how to maintain a good level of infection control.

Requires Improvement

Is the service effective?

Our findings

Staff told us they felt well supported and received supervision of their competence to carry out their work. Records showed that supervision sessions were used to discuss specific people and their needs, care worker's training and development needs and any other issues that arose. One care worker told us, "I had two supervisions last year. I don't think this is a problem, I can talk to my coordinator any time I want" and another care worker stated, "I think we get enough supervisions." However, despite these positive comments we found supervision sessions were not taking place at the frequency required by the provider. The regional quality manager told us supervisions had not been properly checked in the past and had not been completed as frequently as required. Supervisions were supposed to take place every two months. The regional quality manager explained that plans were in place to continue the usual programme of supervisions.

The regional quality manager also told us annual appraisals were supposed to be conducted of care workers' performance once they had worked at the service for one year. Records indicated that care workers had not received their appraisals on time and care workers confirmed this was correct. We found plans were also in place to ensure care workers received their appraisals as soon as possible. We will check this at our next inspection.

People told us staff had the appropriate skills and knowledge to meet their needs. Their comments included, "The carers are good" and "They know what they're doing." Senior staff told us and care workers confirmed that they completed training as part of their induction as well as ongoing training. Records confirmed that staff had completed mandatory training in various topics as part of their induction prior to starting work. These topics included moving and handling people, health and safety and medicines management.

Records and feedback from the management team showed new staff underwent an induction programme in line with national training standards. This included a period of initial training and a further period of shadowing of experienced staff before working as part of the service. The process also involved an online completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Completed modules were signed off by the care worker's field care supervisor.

Care records lacked information about how the service supported people to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Care records contained some information about people's health needs. Care records included details about people's medical histories as well as any current conditions they had. However, there was limited information about what these health conditions were and how they affected people. The regional quality manager explained that where details were lacking about people's health needs, she would liaise with healthcare professionals or the local authority to obtain specific advice or instructions. However, we found there was a consistent lack of written information in relation to people's mental health needs. We did not see any risk assessments or other form of information about people's mental health needs. When we spoke with care workers they demonstrated a good level of

knowledge about people's health needs and demonstrated a good knowledge of how they were expected to support people with these.

People told us they were encouraged to eat a healthy and balanced diet where this was part of the package of care they received. People told us that care workers offered them choices in relation to their food and that care workers knew their likes and dislikes. People's care records contained a good level of information about their dietary requirements as well as detailed information on their likes and dislikes in relation to food. Care workers told us they asked people what they wanted to eat when they visited and where they were required to undertake food shopping for people, they told us they were always given instructions on what to purchase.

People's rights were protected in line with the Mental Capacity Act 2005 (MCA) as the provider met the requirements of the Act. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA, and found that the provider was meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent. One care worker commented "I do have some clients who do not have capacity to make some decisions. I have seen in their care plan that decisions have been made with their families." People's support plans included a mental capacity assessment which determined whether people had the capacity to consent to their care. Where people did not have the capacity to consent to their care, the next section of the form included confirmation of the areas in which people required support with decision making. The final section included an area for recording best interests decisions. Where people needed assistance with decision making, best interests decisions were made in consultation with family members where appropriate and health and social care professionals.

The service assessed people's needs and choices so that care and support was delivered in line with relevant legislation and standards to achieve effective outcomes. Care was delivered in accordance with internal policies and procedures in a number of areas, including medicines management, safeguarding vulnerable adults and infection control. Policies identified the procedures to be followed and relevant legislation and standards that required adherence in order to do so. For example, the infection control policy included references to many pieces of legislation including the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013 and RIDDOR. We spoke with the regional quality manager about the provider's compliance with legislation and standards and she explained that she worked to ensure that all care staff were given up to date training that was delivered in accordance with current standards and legislation. She explained that if she was unsure of a particular course of action, she was able to contact external professional teams for further advice. As an example, she explained that due to an identified need in medicines administration, up to date guidance had been sent to care workers and additional training provided to ensure that care workers were complying with the required standards of practice.

The service worked in co-operation with other organisations to deliver effective care and support when needed. We saw examples in people's care records of advice that had been sought from external professionals in relation to people's care. For example, in one care record correspondence with a wheelchair company to ensure that this was available for the person to use.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave positive feedback about their regular care workers. People told us, "I think most of the carers are kind but…I don't always see regular staff", "I think the majority of staff have a good approach and are caring" and "They are very kind and caring, they couldn't be better." People and their relatives told us they were treated with kindness and compassion by their regular care workers. Most people we spoke with confirmed that they were usually seen by the same care workers and said that positive relationships had developed.

However, some people told us they were regularly seen by different care workers and this had an impact on their ability to develop a relationship. People told us, "When I have a regular carer everything runs smoothly" and "My regular carer is fine but some of the others just go through the motions." Care workers told us they usually worked with the same people so they had got to know each other well. However, some care workers confirmed that there were instances when they were sent to see people who were not their regular clients. Care workers told us, "I have regular clients, but I know some of my colleagues have to see different clients" and another care worker told us, "I had some problems before where I was seeing different people all the time, but I now see regular clients and it has really helped me to get to know them well." Care workers demonstrated a good understanding of people's needs and their life histories. They were well acquainted with people's habits and daily routines and most people confirmed this.

We spoke with the regional quality manager about the issue of continuity of care and she informed us that work had been undertaken to ensure that care workers were consistently supporting the same people. At the time of our inspection approximately 80% of people were assigned care workers who were supposed to continue seeing them on a regular basis.

People's independence was respected and promoted by staff. A care worker told us, "I take every opportunity to involve people in what I'm doing" and another care worker stated, "I help people with what they want done, I don't tell them what they should be doing."

The service supported people to express their views and be actively involved in making decisions about their care and support. The management team conducted quarterly reviews of people's care. However, due to recent staff changes, they were delayed in responding to some concerns that had been relayed to them. Plans were in place to respond to all concerns that had been relayed through reviews. The regional quality manager explained that all issues that had been identified through recent quality monitoring were logged and investigated in the same way as any other complaint. Actions were in the process of being taken to rectify issues.

Care workers explained how they promoted people's privacy and dignity and gave us practical examples of how they did this. One care worker told us, "Some of my clients have family around when I visit, but I always check with people if they want the family to leave the room." People we spoke with also confirmed their privacy was respected. One person told us "The staff do ask me if things are ok when helping with personal care and consider my privacy."

People's cultural and religious needs were assessed and met. Care records gave some details about people's needs, and the regional quality manager confirmed that these were identified when people first started using the service. When we spoke with care staff they had a good level of knowledge about people's culture and spiritual beliefs and how this influenced and contributed to the support they provided.

Requires Improvement

Is the service responsive?

Our findings

Prior to our inspection we received some information of concern relating to the timeliness of complaints investigations. We found the service had a complaints policy which outlined how formal complaints were to be dealt with, but this was not being properly followed. People told us, "I've complained but they take no notice" and "Occasionally someone phones to ask if everything is okay, you tell them and then nothing changes." We spoke with senior staff about complaints management and they told us a number of staff previously responsible for conducting investigations into complaints had recently left the service. This meant that for a period of approximately two months, there was a delay in investigations being concluded. Due to this delay the provider had been unable to put plans in place to manage people's complaints and enable staff to learn from issues raised in a timely manner. We saw that this had been addressed. We saw a complaints tracker was in place to log complaints as well as actions taken to manage the complaint. The regional quality manager was monitoring and dealing with complaints received to ensure that these were resolved satisfactorily.

People and their relatives told us they were involved in the initial preparation of their care plans. Care plans were detailed and provided clear guidance to staff about how people wanted to be supported. However, care was not always fully planned and delivered in accordance with people's wishes. For example, people's timetables of care did not always reflect the outcomes within their support plan. In one support plan we saw the person was requesting assistance with their medicines. However, there was no indication on the timetable as to whether they were actually receiving this support. We also identified some issues within the daily records made by care workers. On some dates for some people, we found there were either limited details or no written details about the care that was provided. We were told that care workers were supposed to return MAR charts and people's daily notes to the office on a monthly basis to be reviewed by the care worker's supervisor. However, due to understaffing, compliance with this requirement had not been monitored and was therefore not always happening. We spoke with the regional quality manager about this and she confirmed that since the provider had now fully recruited care coordinators, they were in a position to meet this requirement going forward.
Assessments covered areas such as medicines administration, skin integrity and mobilising. Support plans included details of the outcomes that people required from their care and clearly articulated the assistance that people felt they needed. Support plans also included a timetable of the care that people were supposed to be receiving and these included details for care workers in what they were required to assist people with.

People's timetables contained a good level of detail about what care workers were required to do. For example, we saw specific written details of what type of food people wanted to eat as well as how they wanted their personal care to be delivered. For example in one support plan we saw details of the cream the person liked to use as well as the location of items including towels.

We saw evidence that people's care records were reviewed annually. Risk assessments and care records were updated after a 12 month period and these included updated details about people's needs. Where people's needs changed before a review was scheduled, people's care records were updated in advance.

Care records included some information about people's involvement in activities where this was relevant to the package of care being provided. As part of the initial needs assessment, the field care supervisor spoke with people and their relatives about activities they already participated in so they could continue to encourage these where they were able to do so within the authorised time limits. People's timetables included instructions about how care workers were required to assist people to participate in activities. For example, if they were required to escort people outside. Care workers gave us examples of the types of activities some people were involved in and how they were required to assist people to do so. For example, such as helping people to do their shopping and attending day centres.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were in place, but these had not been consistently used to good effect. The manager was required to complete a comprehensive audit on a monthly basis which included a check of numerous areas including a sample of care records, all safeguarding alerts and a check of all complaints that had been received. Any outstanding actions were required to be recorded and completed by the next audit. However, due to changes within the management this audit had not been completed. We spoke with the head and regional head of quality about this. They explained that the comprehensive auditing system was an effective means of capturing issues and ensuring improvements if they were completed correctly and on time. In order to rectify the issues that had occurred they explained that a new manager had been appointed who was being trained in the required system of auditing and that in future, the quality team would provide oversight to ensure that this was being completed.

The provider had a clear vision and credible strategy to secure additional improvements in other areas of the service. The provider had a comprehensive action plan that had been devised in consultation with the local authorities commissioning care and we found this identified the areas of concern we found. Immediate action had been taken and some immediate improvements had taken place. For example, care worker compliance with the electronic monitoring system had significantly increased.

Care staff demonstrated they were familiar with the values of the organisation and said these guided their work. Care workers told us, "We work to support people to lead independent lives" and "We offer people choices so they can make decisions in how they want to live." Senior management sought to ensure these values were fully embedded in their work and had recently published a staff news magazine in order to further embed these ideas. An article entitled 'new vision and values revealed' encouraged care workers to send in stories from their work which reflected the values in action.

The provider understood their responsibility to notify CQC of particular events and notifications were received as required.

The provider was working to promote an open culture for staff. Senior staff explained that due to the recent changes in senior management and other staff, the service had experienced some disruption. The newly appointed manager also explained that she was aware of the issues the service had experienced with morale as a result. All senior members of the management team explained they were working to create stability within the staffing structure and improve systems of support including supervisions and team meetings. One care worker told us "I know things have been changing, but I think we've been treated well during the process."

Staff told us they worked well as a team and enjoyed their job. One member of staff said, "I get the support I need." Another told us, "Things have been going well. I love my job and that's all that matters to me."

Care staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities

were made clear to them when they were first employed. Care staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result.

Internal reviews were conducted of people's care on a quarterly basis. People were asked questions about the care they received in areas such as the timeliness of care visits, the quality of the care and whether the care worker was appropriately completing timesheets. The feedback obtained was then supposed to be analysed and an action plan put in place to manage any areas that required improvement. The timeliness of monitoring reviews had been disrupted due to the changes within the management structure, however, these were had recently resumed. The regional head of quality explained that she was logging all issues and dealing with these as complaints as well as reporting issues to the local authority and where necessary to the CQC to ensure that all parties were aware of identified issues as well as actions taken to rectify these.

The provider worked with members of multidisciplinary teams in providing care to people where needed. This included mental healthcare professionals, people's GPs and their pharmacists. Where issues were identified improvement plans were put in place.

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 The provider did not always appropriately assess the risks to the health and safety of service users and do all that is reasonably practicable to mitigate any such risks. 12(1)(a) and (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always effectively operate processes to monitor and improve the safety of services provided and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. 17(1) and (2)(a) and (b).