Olive Home Care & Support Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 17 and 20 August 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in to speak with us and that we could meet with people using the service.

Olive Home Care and Support is a domiciliary care agency registered to provide personal care and support services to a range of people living with physical disabilities, mental health needs and people living with dementia. The service provides personal care to people living in their own houses and flats in the community. At the time of our inspection the service was supporting 20 people.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 1 August 2017, the service was rated Requires Improvement. This is the second time the service has been rated 'Requires Improvement.' This was because the provider had not fully ensured staff were suitably trained and deployed to meet people's needs in a way that met their needs.

At this inspection we identified further areas of practice that required improvement, including breaches of regulation in relation to safe recruitment, safeguarding, safe care and treatment and quality assurance and governance.

Practice around the administration of medicines was not consistently safe. Staff were trained and assessed as competent to administer medicines. However, practice around the administration and recording was not consistently safe. There was a lack of guidance for staff on how daily and 'as required' medicines should be given. People's prescribed medicines were not always given in the way the prescriber intended and the governance of medicines was not robust enough to ensure that shortfalls were addressed without delay.

People and their relatives had made a number of ongoing complaints in relation to delayed and missed calls since the last inspection. Social care professionals and two local authority professionals had worked closely with the provider to reduce the levels of missed calls. During this time people were at an increased risk of not having their care needs and preferences met including, access to their medicines, food, personal care needs and feeling secure. One person noted in a complaint to the provider that a delay of two hours in their night time call had left them feeling unsafe. Records demonstrated that although some improvements had been made, that not all calls were being made in a timely way that promoted people's needs being met.

Recruitment procedures had not ensured that staff were safe to work with vulnerable people, as the registered manager and provider had not always robustly carried out their own recruitment and

safeguarding policies.

People were not always protected from the risk of harm, abuse or potential abuse. Staff could tell us about different types of abuse and were confident the registered manager would take concerns seriously. However, on at least two occasions, peoples' wellbeing was not promoted as the registered manager did not effectively identify, or act on, evidence that abuse may have occurred. They also failed to notify the CQC of these incidents and the local safeguarding bodies, or do so in a timely way. Where accident and incidents had been identified and records completed, action were not always fully documented to reduce the risk of reoccurrence and effectively mitigate the risk of further injuries.

Quality assurance systems failed to monitor the overall quality of the service and to identify short falls. The registered manager and provider recorded information relating to quality assurance areas, however they failed to scrutinise the information and design effective responses to address higher risk shortfalls including medicines management and missed calls without delay.

The registered manager did not fully understand their responsibilities in relation to their registration with the Care Quality Commission (CQC). The provider had not consistently submitted notifications to the CQC as is required by law.

People did not always receive personalised care and support. The changing needs of people were not always considered and consistently supported by detailed care plans. Communication at the service was not consistently effective. The electronic monitoring systems was still being embedded and records were not consistently completed by staff.

People told us that staff were caring. One person told us, "They are very nice. I can't say more than that." We observed people and staff interacting in a comfortable manner.

In July 2018 the provider reduced the number of people they supported to 20 and limited their geographical area of the service. People and relatives who were currently using the service told us that they had recently seen improvements in the service. One relative told us "The service has improved recently, more regular carers, before it wasn't the case, it's improved a bit in the last month."

The registered manager recognised the principles of Accessible Information Standard and the benefits of services recording and meeting people's ongoing information and communication needs.

People were supported in line with the principles of the Mental Capacity Act (MCA) 2005. People felt that they could make some choices and relative felt they were treated as individuals and that their privacy was respected. One person told us, "Yes, they do respect my privacy. I have a key safe so they let themselves in and they always call out and knock on my door before coming in."

The registered manager and staff worked closely with health professionals. Staff were aware of the importance of people remaining as independent as possible and people told us they were supported to do as much as they could for themselves. One person told us, "I can move around with my trolley with a little tray on it. I'm able to move things from one place to another. It's very useful."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version on the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People had not always been protected from risk of abuse as the registered manager had not always identified when an incident or concern should be raised with the safeguarding body.

People's medicines were not always managed and administered safely. People's individual needs were not consistently safely met as staff were regularly late and calls were missed.

Staff were not always recruited using safe procedures.

People's rights in relation to their diverse needs were understood by staff.

Is the service effective?

Requires Improvement

The service was not always caring

Staff were not consistently compassionate and caring

People's communication needs were promoted by staff that knew them well and listened to them.

People were involved in decisions that affected their lives and their important relationships respected.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were not consistently compassionate and caring

People's communication needs were promoted by staff that knew them well and listened to them.

People were involved in decisions that affected their lives and their important relationships respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records and plans did not consistently give enough detail and guidance to ensure people received personalised care when their needs changed.

People's communication and sensory needs were considered in care planning and staff were familiar with how they may use expressions and gestures when communicating.

People had access to technology to promote their independence at home and in the community.

Is the service well-led?

Inadequate

The service was not always well led

Quality assurance systems were in place however they did not effectively identify shortfalls in quality and safe care practices or promote improvement.

The service did not always notify the CQC of incidents that fell under the criteria for notifications of other events.

The service worked with health professionals and the local community to develop a community presence.

Olive Home Care & Support Limited

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 gave the service 48 hours' notice of the inspection visit because we needed to be sure the registered manager, staff and people we needed to speak to were available.

The inspection took place on the 17 and 20 August 2018 and was announced. It included visiting the site office, and speaking to two people in their homes. We also spoke with people and relatives by telephone prior to the site visit so that we could further understand their experiences. The inspection team consisted of two inspectors and an expert-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.

Before the inspection, we gathered and reviewed information we held about the service. This included statutory notifications and complaints in relation to the service and information shared with us by the commissioning local authorities. A statutory notification is information about important events which the service is required to send to us by law. The inspection was prompted in part by notifications indicating potential concerns about the management of risk in relation to medicines, continence care, missed calls, staff recruitment and allegations of abuse that were being looked at by two local authorities under safeguarding.

The registered manager had completed a Provider Information Return (PIR). This is information we require providers to send us, to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed care and support and spoke with four staff, the registered manager and provider. We looked at six people's care plans, three staff files, staff training records, policies and procedures, quality assurance documentation and information and policies in relation to people's medicines. We spoke with six people using the service, four relatives, two local authority contracting professionals teams and two social care professionals. This was so we could further understand the experiences of people receiving a service from Olive Home Care and Support. We have included their feedback in the main body of the report.

At the last inspection on 1 August 2017, the service was rated Requires Improvement. At this inspection we found the service continued to be rated as Requires Improvement.

Requires Improvement

Is the service safe?

Our findings

Before the inspection, we had received information of concern that people's medicines and personal care was not always provided in a way that met their needs, that staff had missed or been late for visits and that safe recruitment processes had not always been followed. People and relatives told us that they felt safe and that the service had improved recently. One person told us, "Yes, I feel safe. They come in the morning near enough on time." Another person told us, "Yes, they give me my tablets, and they make sure that I take it I'm sure they check that it's gone." A relative told us, "The service has improved recently, more regular carers, before it wasn't the case, it's improved a bit in the last month." However, despite these positive comments, observations made during the inspection supported the feedback received prior to inspection and we have identified areas of practice in relation to medicines, personal care, managing risk, staffing deployment and recruitment that required improvement.

The registered manager acknowledged that since the last inspection in August 2017 shortfalls in staff performance and a high level of missed calls had impacted on people's care. People and their relatives had made a number of complaints and local authorities had undertaken a number of safeguarding investigations relating to the service. The registered manager told us that in response to these concerns they had introduced an electronic call monitoring system that had been implemented in July 2018, reduced the number of people they supported to 20 and would now only provide support to people within a reduced geographical area.

People were not always supported to receive their medicines safely. Medicines were administered by staff that were trained and assessed as competent to do so. Staff described how they would carry out safe medicines practice in people's homes, including gaining the person's consent and actions they would take if they noted that medicines had not been given. However, people's medicines administration records (MAR), daily records and staff feedback demonstrated that practice was not in line with their descriptions. The recording of medicines was inconsistent and not in line with the provider's medicines policy that detailed information would be recorded on the MAR sheet and any medicines errors investigated. For example, staff told us gaps in MAR sheets were reported in a number of ways including; people's daily records, a closed social media app and or reported to the registered manager by phone. There was a lack of incident reports to demonstrate that potential missed medicines were fully investigated and acted on. Records could therefore not adequately demonstrate or give the registered manager assurance that people had safely received their medicines as intended by the prescriber to ensure their wellbeing.

Staff feedback, records and our observations demonstrated that there was a lack of guidance for staff within peoples care planning and MAR sheets, in relation to people's medicines including; the date, dose and method that daily medicines should be given. There was a lack of guidance in relation to 'as required' medicine's including those prescribed to temporarily manage pain and skin integrity. Prior to the inspection we had received feedback relating to local authority safeguarding enquiries and contract audit activity carried out between December 2016 and July 2017. These evidenced a number of shortfalls in medicines administration practice that had not resulted in long term harm where people missed or had their medicines delayed.

Since the last inspection in August 2017, the service had received and recorded a number of complaints from people and their families that demonstrated that staff had not been deployed effectively or in a timely way. For example, in June 2018, a call scheduled for 5pm had not taken place by 7.20pm, this had resulted in the person having to arrange their own meal. Another complaint in April 2018 noted that a person was delayed in receiving their medicines and lunch, due to a staff member not arriving for a scheduled call. In May 2018 a night time call was provided two hours later than scheduled which made the person feel unsafe. This demonstrated that where people relied on support from staff for example, to prepare a meal or take their medicines, receive personal care, the services scheduling of calls, the timeliness of staff travel arrangements and staff failure to follow instructions had placed them at risk of not always receiving the assistance they needed when they needed it. This increased the risks of people not having their nutritional, physical and emotional needs met or becoming ill due to not having their medicine.

Further to this, people did not always receive care from staff that knew their care needs well. A number of staff had left the service due to performance and personal reasons and the registered manager acknowledged it was difficult to recruit staff with suitable skills. The registered manager told us and people and their relatives confirmed that the punctuality of visits had improved since July 2018. Staff told us they visited some people regularly, and provided cover at short notice due to staff shortages. One relative told us, "They used to be late a lot but that's improved lately, and they didn't always phone up but they do now." However, there was still evidence that demonstrated that these improvements needed to be further embedded and that calls were not consistently happening in a timely way. For example, we looked at the electronic monitoring 'call verification' records and these demonstrated that, in August 2018, there were still gaps in the recording of calls and calls taking place more than 30 minutes after they were scheduled. The registered manager, records and local authority contracting professionals told us that there had been a significant level of missed calls over a sustained period of time. The service would therefore need to demonstrate that improvements in the attendance and punctuality of calls by more regular staff would need to be sustained over a defined period of time to ensure the service provides caring staff.

The above evidence demonstrated that, people did not always receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care visits and the shortfalls in medicines practice placed people at risk of receiving late calls, or having missed calls. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment checks were not effectively carried out to ensure staff were safe to work with people. Staff records did not always demonstrate processes were carried out in line with Olive Home Care & Support's recruitment and safeguarding policies. For example, that the registered manager had ensured staff were eligible to work in the UK, that suitable references had been gained and that full checks had been completed with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. One agency staff member applying for post with the service, had been provided by an agency that the provider of Olive Home Care & Support was the registered manager of. The registered manager and provider were not able to provide evidence that the agency staff member proof of identity. In addition, references were not always signed by the referees in order to establish their authenticity. In relation to another staff member the registered manager had been made aware post interview of potential concerns relating to their recent employment history and conduct. The registered manager had completed an individual risk assessment in relation to the staff member. However, the risk assessment did not demonstrate that risks had been mitigated to people in receipt of a service. For example, the assessment detailed that the likelihood of the risk occurring 'was difficult to assess.' The control measures put in place noted that the staff member would be monitored closely. However, the registered manager could not evidence how this staff member was to be monitored closely in accordance with the risk assessment.

We discussed the rationale of this with the registered manager and provider, questioning how they could be assured of the agency staff and staff member's suitability for their roles. The registered manager told us that they would make further enquiries in relation to each staff members circumstance and would be applying for updated checks. However, they were not able to set out how they had gained reasonable assurances during the recruitment processes and not effectively followed their own procedures.

This demonstrated that the recruitment procedures had not been operated effectively and had failed to ensure that the people employed to carry out regulated activities were of suitable conduct to work with vulnerable people. This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always fully protected from the risk of potential harm through abuse. Staff told us they had access to safeguarding training, policies and procedures and were aware of how to report different types of abuse that older people living in the community may experience. People, relatives and staff told us that they were happy to raise concerns and felt their concerns would be taken seriously and acted on by the registered manager. One relative told us, "I have the number of the office if I have any concerns." However, during the inspection we identified two potential safeguarding concerns where the registered manager had not identified that abuse or potential neglect may have occurred in relation to four people's medicines and one person's skin integrity. For example, during one person's personal care call, a staff member had observed broken skin that they felt had occurred due to two barrier creams being used together. They made the registered manager aware of this. The registered manager advised all staff of the correct administration procedure. However, they had not recorded this action in the person's records, completed an incident report, updated their care plan and risk assessments or identified whether the incident could meet the threshold for safeguarding enquiries to be alerted. The registered manager failed to report the incident to the local authority, so that they could be fully considered and investigated. We shared our concerns with the registered manager and the provider and two concerns have been raised with the local authority in relation to the incident and the medicines concern.

This demonstrated that the provider failed to ensure that there were systems, processes and practices in place to protect people people's rights to be safe from the risk of potential abuse and harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place for the recording of accidents and incidents and identifying environmental and specific areas of risk. For example, people experiencing falls were supported to access emergency services and see their GPs. Where repeated falls had occurred, referrals were made to health practitioners who could assess their needs in relation to adaptations and equipment that would reduce the likelihood of the falls reoccurring. Staff were provided with guidance in relation to environmental risk, lone working, infection control and potential hazards such as fire, pets and utilities. There was also guidance available detailing what to do if people did not respond when staff attended a visit or were delayed. Staff received infection control and food hygiene training and told us that they had access where required to clinical waste equipment and systems in people's homes. Staff were aware of the importance of using personal protective equipment (PPE) to avoid cross contamination and relatives confirmed that staff always used gloves when providing personal care.

Staff and the provider told us the service considered people and staff rights in relation to their diverse needs and human rights. A number of staff had received training in equalities and diversity awareness and told us they understood the importance of protecting people from all types of discrimination. However, although the registered manager confirmed that their systems were being developed to include equalities preferences within care plans this information was not detailed on people's care plans during the

inspection. This is an area of practice that needs improvement.

Requires Improvement

Is the service effective?

Our findings

People and the relatives were positive about the care given and felt confident that staff had suitable skills and training. One person told us, "They are trained well enough for me. They do the cleaning and sometimes shopping for me." A relative told us, "I think that they are, they seem to be fully trained. Sometimes they have trainees with them." Despite this feedback we found areas of practice that needed improvement.

People and the relatives felt confident in the skills and knowledge of the staff supporting them. However, the registered manager had not consistently ensured that staff received appropriate and consistent training and support. Staff told us they received training in relation to the Mental Capacity Act 2005 (MCA), moving and handling, medicines administration and safeguarding. Records demonstrated that the service had a system in place to monitor staff training. A number of staff had training that was specific to the needs of the people using the service including; dementia, wound care and equalities and diversity training. However, a number of records including moving and handling training, referred to courses attended with their former employers. The registered manager had not consistently assessed staff competency in these areas making them reliant on the quality of training delivered by the former employers and staff consistency and experience to inform practice and ensure people's safety.

Staff were positive about how they were supported through weekly meetings, where they spoke about people's needs and their own welfare. They confirmed they had inductions that included shadowing other staff and meeting people to become familiar with their routines and how to meet their needs. One staff member was also supported in relation to their reading and writing skills and told us that they felt the access to new phone based electronic monitoring systems were helpful as they were more comfortable texting than writing. However, they told us they had not always received regular supervisions, appraisals and observational 'spot checks' of their practice in inform their role. The registered manager told us and staff agreed, that their ability to support staff in carrying out their roles through more regular supervisions and observations of staff competency would improve with the resource of an additional manager, and that the provider was in the process of recruiting to this role. We have therefore identified the embedding of more consistent supervision and competency arrangements as an area of practice that needs improvement.

Care plans were designed around the needs of each person and staff told us they were informative and responded to people's needs. Initial assessments were carried out by the registered manager to ensure the service could meet the person's needs. Records were accessible and gave descriptions of people's assessed needs and the support staff should provide to meet them. The service demonstrated some areas of consistent practice in supporting people to have ongoing healthcare support. People, their relatives and records described that the majority of health care appointments and care needs were co-ordinated by relatives. When this was not possible, care staff were also available to support people to access healthcare appointments if needed. People also had regular access to health practitioners including occupational therapists, physiotherapists and district nursing teams when required.

People were supported to access food and drink of their choice. Where required Malnutrition Universal

Screening Tools (MUST) were in place. These are tools that can identify adults who are at risk of malnutrition. Staff worked in tandem with family members, some of whom prepared meals and supported mealtimes to ensure people's nutritional needs were met. One relative told us, "A family member does the shopping online. Our relative gets what they like to eat and the staff prepare it for them." Staff were aware of the importance of ensuring people had regular access to food and fluids, and told us they had received training in food safety and were aware of good practice in relation to food hygiene. People's food preferences were detailed in their care plans.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's rights in relation to making choices were protected. Staff demonstrated that they understood and worked in line with the principles of the Mental Capacity Act 2005. For example, one staff member told us they always respected someone's right to say no to support, "It's people's choice if they don't want to be supported with personal care, or are not ready to take their medication." Another staff member told us how they ensured that people with communication difficulties were offered choice, by offering items to choose from and responding to their facial expressions and gestures.

There were policies in place and staff told us what action they would take if they had concerns about a person's capacity to consent including speaking with their manager, contacting a social worker to ensure a capacity assessment or best interest decision making assessment could be completed. The registered manager confirmed that MCA training was part of new staff member's induction. People's care records included details in relation to people's initial capacity assessments, including where family members had authorisation to make decisions on their behalf and initial mental capacity act assessments.

Requires Improvement

Is the service caring?

Our findings

People and relatives, told us that staff were caring. One person told us, "Oh yes, they're always saying how are you, they seem like they're concerned." Another person told us, "They are very nice. I can't say more than that." A relative told us, "On the whole they are very caring." Despite, this positive feedback, we found areas of practice that needed to improve.

As the provider had recently reduced the number of people being supported by the service, we looked at the provider's complaint records so we could further understand the experiences of people who were no longer being supported. Records demonstrated that staff were not consistently compassionate and caring. For example, in early August 2018, a relative's recorded complaint noted that a carer 'appeared to be rushing and not paying attention." A call in July 2018 was recorded as not taking place when a second carer had not attended a visit. On contacting them to ensure their whereabouts, the colleague told them, "I'm at home, I'm tired and my feet are killing me." On each occasion the registered manager addressed the performance concerns with staff, however there were a number of occasions since the last inspection in August 2017 where complaints demonstrated staff were not consistently carrying out their role, in line with guidance or management instruction to ensure that people received timely and compassionate care. The registered manager had acted to manage staff conduct and performance and noted lessons learnt on each occasion. However, there were repeated patterns of conduct that would suggest that further embedding of a compassionate culture was needed through robust staff supervision and support arrangements within the service. We have therefore identified this as an area of practice that needs improvement.

People's privacy in relation to confidential information was not always promoted. Care plans and electronic records were kept secure and access limited to people who needed to know. However, staff regularly used a social media group application which was separate to the formal electronic monitoring systems to share information. For example, in relation to potential medicines errors. This demonstrated that people's information may not always remain secure and be accessible for auditing to ensure care planning was carried out in a safe way. This was fedback to the registered manager to address. We have therefore identified this as an area of practice that needs improvement.

People told us their privacy was respected. Staff understood their responsibilities in maintaining people's dignity while supporting personal care. One person told us, "Yes, they do respect my privacy. I have a key safe so they let themselves in and they always call out and knock on my door before coming in." One relative told us, "Yes, they treat my relative with dignity and respect, and they show discretion when giving them personal care."

Staff felt they knew people's needs and that they had enough time and information within care plans, electronic daily records, and team meetings to meet their needs. For example, the service demonstrated some areas of consistent practice in supporting people's important relationships to be respected. Staff were respectful of maintaining people's important relationships and understood that established couples may still want to carry out some part of each other's care. For example, one person's relative supported them to eat, while another's family ordered their food deliveries.

People and their relatives confirmed they were included and involved in making decisions about their care. People told us they were supported to be as independent as they could be and make choices. One person told us, "They encourage me to do things for myself, even in front of them I do it myself." A relative told us, "Yes, they try to keep my relative as independent. They encourage them to come downstairs." Where people did not have relatives involved, the registered manager was aware that people had the right to have an advocate involved. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their relatives told us they were offered choice in an accessible and meaningful way. One person told us, "They always give me a choice, but some of the time they don't ask me as they know the answer." A relative told us, "They do listen to my relative and they try to guide them in the right direction." We observed staff using a range of communication methods. Staff listened, observed people's responses and ensured they acknowledged what the people said and checking they had understood them. Consent was asked for and gained prior to support being given and people and their relatives confirmed this.

People's communication needs were met. During the inspection we visited one person who lived with potential self-neglect and memory issues during a regular support visit. The staff member could describe the person's daily routines, their background history and likes and dislikes. They spoke with the person about their interests in planes, making models as well as discussing their needs for the day. Throughout the visit the person spoke openly and was comfortable in the staff member's presence, exchanging humour and seeking reassurance when less confident. People and their relatives told us staff adapted their tone and always gave them time to express themselves or to confirm that they had understood what had been said to them. One person told us, "I've had a stroke and it effects my speech and I really have to think before I speak. They take time to talk to you and have a conversation, which I really like."

People's dignity and human rights were considered. Staff understood the importance of respecting expressed views. Where people requested their support to be provided by particular staff who they felt comfortable with, for example due to gender, this was respected. We observed staff responding to peoples wishes and promoting their independence during the inspection. For example, one person was initially unsure why they needed care. The staff member remained gentle in the manner when prompting person providing time for them maintain their independence. The person told them, "I like to do things myself." The staff member reassured them, "I know I'm just here to help you."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt listened to by staff and involved in their day to day choices about their care and support needs. One person told us, "Most of the time I deal with everything myself, as I don't have any family." A relative told us, "My relative well supported and doesn't need any more than I've asked for, and they are very good." Another relative told us, "They take our feelings into consideration on a day to day basis." People, their relatives and, when needed, health and social care professionals were involved in developing initial care plans. Despite this feedback we found areas of practice that needed improvement.

People were not always supported with personalised care. People's needs were assessed before the care and support service was agreed. These assessments were completed by the registered manager so that they could ensure they were able to meet the person's needs. However, as people's needs changed, or new risks were identified, care plans did not consistently provide details of the risks or provide guidance for staff to ensure these risks were mitigated. For example, within the initial assessment process of one person living with diabetes, the registered manager noted that the symptoms of 'hyperglycaemia' or high blood sugar levels had been discussed as part of the assessment. Although the care plan detailed that health professionals were involved regularly to monitor their health needs and that staff should regularly prompt the person to independently monitor their blood sugar levels, there was no detailed guidance or risk assessments for staff to follow in relation to how to respond to the person's diabetes needs; including fluctuations in their blood sugar levels that may require action from the staff member or medical assistance. Therefore, the registered manager had failed to carry out their own systems and processes and ensure that staff had suitable guidance to inform what actions they needed to take to manage the person's wellbeing.

Further to this, there were shortfalls in how the risks relating to another person at risk of self-neglect and environmental hazards were assessed and mitigated. For example, although staff could demonstrate their knowledge of the environmental risks posed to the person and demonstrated that they carried out control measures such as unplugging electrical items after use and not storing hazardous liquids within the property. Records did not demonstrate that these risks were detailed, or control measures recorded and care plans updated to ensure all staff had robust guidance and that risks were assessed and mitigated to ensure people's safety.

This demonstrated that people were placed at risk, as the registered manager and provider did not have adequate systems and processes in place to fully assess, accurately record and identify where safety and care needs were compromised. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's communication and sensory needs were considered in care plans. Staff were able to describe how they adjusted people's communication and understanding needs including; gestures and facial expressions. The registered manager recognised the principles of Accessible Information Standard and the benefits of services recording and meeting people's ongoing information and communication needs.

Care plans were personalised and discussed people's backgrounds, likes and dislikes, daily routines,

interests and the important relationships in people's lives. For example, one person enjoyed watching TV and accessing social media sites on their tablet, they had an established long-term partner and a pet and their routines were also included in the information shared. People were asked if they had a preference in the gender of their carers and this was recorded in their care plans. Relative's told us that people's emotional needs were supported. One relative whose loved one had experienced periods of agitation told us, "The carers are really good with them. They are very patient and calm."

People told us they were supported to be as independent as possible in accessing their home. The registered manager and staff were aware of the importance of people remaining as independent as possible and people told us they were supported to do as much as they could for themselves. Staff promoted people's independence, by supporting them to choose what clothes they wished to wear. One person told us, "They encourage me to do what I can." Another person told us, "I can move around with my trolley with a little tray on it. I'm able to move things from one place to another. It's very useful." Where people required access to technology to promote their independence at home and in the community the provider supported and promoted access to this. One person's relative told us, "My relative has a lifeline and wears the bracelet, the fire brigade has installed smoke alarms, heat detectors in the kitchen." Another relative told us, "We have a stairlift so the carers can get my relative up and down the stairs easily. I give my relative their breakfast before they arrive then they get them washed and dressed upstairs and bring them back down." Staff encouraged the use of these items including; portable telecare alarms, bath hoist, pressure mattress, adjustable bed and stairlifts to ensure people could live as independently as possible in the community. Staff were able to describe how they would respond to a medical emergency. For example, if someone had a fall they would assess their wellbeing and ensure the emergency services, their relatives and the registered manager were contacted.

We did not see any end of life care planning within records, and the registered manager confirmed that the service was unlikely to provide end of life care. However, they were confident that people's individual wishes in relation to advance care planning would be known if needed and planned for through initial assessment and working closely with relatives.

People and relatives, were aware of how to make a complaint and felt their concerns would be taken seriously and responded to by the registered manager. One relative told us, "I have the number of the office if I have any concerns." The complaints policy and procedure was available to people and the registered manager had a system in place to record and investigate any complaints received.

Inadequate

Is the service well-led?

Our findings

People, relatives and staff gave mixed feedback on whether the service was well-led. One person told us, "I don't know." A relative told us, "On the whole they are very caring. There's been a few ups and downs but it's all very settled now." Another relative told us, "They used to be late a lot but that's improved lately, and they didn't always phone up but they do now." We spoke with two local authority contracting professional's teams who had been working with the service since the last inspection to address significant issues. They told us that the registered manager and provider had not ensured or demonstrated suitable improvements on service delivery standards. Our own observations supported the feedback we received and we have identified areas of practice in relation to quality assurance that required improvement.

Quality assurance systems were in place to monitor the running and overall quality of the service. However, they did not robustly demonstrate the registered manager's and provider's overall ability to ensure people's care needs were met. There was a sustained failure to identify and mitigate risk, provide safe personalised care and continually improve the quality of care.

This is the second consecutive time that the service has been rated as Requires Improvement. At our last inspection in August 2017 we found that quality assurance systems needed to improve in relation to their audit processes, missed calls, staff awareness of safeguarding, training and medicines practice. At this inspection the registered manager and provider told us they had been introducing an electronic monitoring system over a number of months to further inform their quality assurance and audit processes. The Provider Information Return (PIR) which was completed in June 2018 stated in relation to quality assurance, "The manager is now familiar with the 'carefree' software, therefore electronic logs are kept and reviewed. This includes, complaints, safeguarding, CQC notifications, training. Feedback is obtained from clients and their relatives as to how they find the quality of the service. Staff are monitored closely through regular spot checks and supervision.'

The registered manager was able to provide us with collated information in relation to missed and late calls, complaints, daily records, safeguarding's, CQC notifications and medicines audits. However, they were unable to demonstrate that the electronic system was fully embedded or that their systems of recording, although improving, were of a level of detail or quality to ensure they could ensure the quality of the service. Systems did not demonstrate that trends and themes were monitored to identify shortfalls in practice and ensure improvements. There were inconsistent records of daily visits, care planning and safeguarding incidents and staff were still not demonstrating that they could use the system effectively after a number of months of being supported to use the system.

The registered manager and provider's systems and processes had not always ensured people's well-being by providing staff with guidance that was specific to people's needs and identified, assessed and mitigated risk. Guidance was not always responsive to the needs of people. For example, one person's catheter had been dislodged during a moving and handling procedure and this had resulted in a safeguarding concern being raised by a health professional. The person's care plan and risk assessment had not been reviewed or updated to guide staff on how to reduce the likelihood of this type of incident reoccurring during moving

and handling.

Further to this, another person's care plan and records lacked an assessment of risk or detailed guidance in relation on how staff should monitor or respond to fluctuations in the person's skin condition. This reduced staff effectiveness in being able to inform the involved health professionals of changes in signs and symptoms to promote the people's wellbeing. Records we observed and feedback from staff demonstrated that there were inconsistencies in practice, in relation to diabetes, mobility needs, skin integrity issues and catheter care needs, however the providers systems and processes had failed to identify these shortfalls.

People's diversity was not always promoted within their day to day care planning or initial assessment of need carried out by the provider. For example, people's religious, gender identity and cultural beliefs and how these were expressed were not detailed in care plans, and staff were not consistently able to demonstrate that they could encourage people who may to express these areas of their life if it was important to them. This demonstrated that there were shortfalls in the providers system and processes in relation to the auditing of records and the promotion of people's equalities rights.

The registered manager and provider told us that they worked together in relation to quality checks and audits. The provider told us, "I check what the registered manager checks and the responses they give to complaints. We do the recruitment together." However, there was a lack of a planned scheduling of audits that could identify and prioritise improvements required in areas of significant risk, including late visits and medicines practice. For example, medicines audit records between April 2018 and July 2018 evidenced that four people's medicines records had a number of gaps over this period. The registered manager had identified that there was no evidence that some of the medicines had been administered. They noted 'lessons learnt' from the audits including; 'staff made to do training again,' 'carers spoken to about the importance of record keeping'. However, the registered manager did not increase their level of scrutiny in relation to the deterioration in medicines practice or monitor improvements, to ensure further risks were mitigated without delay and the likelihood of reoccurrence reduced.

Further to this people were not always protected from the risk of abuse and potential harm as the as there was no audit of incidents that could potentially meet the safeguarding threshold or systems and processes to ensure the local authority procedures were followed to identify safeguarding concerns in relation to poor skin integrity and medicines administration practice. The service had therefore failed to share these concerns with the appropriate bodies to work in a timely way to ensure they were investigated.

People were not always protected from the risk of potential harm, as there was no audit of the recruitment systems and processes to ensure the providers own standards were followed. In addition, the provider and registered manager failed to fully investigate concerns they were made aware in April 2018 of allegations shared with the local authority that the service's recruitment processes, and care delivery including medicines practice were not being suitably carried out. In response to this the service provider and registered manager wrote to people using the service and the Care Quality Commission to deny the allegations and assure people of their safe practice. Therefore, the provider had failed to review their systems or investigate these concerns fully and in doing so missed an opportunity to learn from feedback.

This evidence demonstrates that people were placed at risk, as the registered manager and provider did not have adequate systems and processes in place to make improvements or to fully assess, accurately record and identify where safety and personalised care needs were compromised. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Olive Home Care & Support's systems and processes did not always promote a person-centred service

culture that ensured staff were clear about their responsibilities. Staff told us they felt they understood their roles and had access to information and advice about people's needs in care plans including team meetings, policies and daily records and contact with the registered manager. They recognised that staffing had been, and remained, an issue that impacted on the service. One staff member told us, "It was chaos when I started and I'm an organised person." They fed back that the registered manager was struggling to recruit staff and that 'unsuitable people' who lacked 'professionalism' were being employed. They told us that the registered manager was trying to make improvements but felt they lacked support and would benefit from a care-coordinator to improve the oversight of the service.

The registered manager and provider confirmed the service required another layer of skilled management to ensure staff performance was effectively managed and quality assurance improved. The registered manager told us that the provider had been supportive of different ideas and approaches they had taken to try and improve the recruitment of staff. They felt it was the most recent decision to reduce the numbers of people that had made the service more manageable, and that 20 people were the right amount of people to support with the current arrangements.

The registered manager did not demonstrate that they understood their full responsibilities in relation to their registration with the Care Quality Commission (CQC). The provider had not consistently submitted notifications to the CQC as is required by law. At the time of the site inspection the CQC had received two statutory notifications in January and August 2018 in respect of safeguarding allegations. The service's own records demonstrated that there had been four allegations of abuse, two of which the service had been advised of by the local authority in June 2018. At the time of the site inspection the CQC had not received statutory notifications in respect of the June 2018 safeguarding concerns. This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 and will be dealt with outside of the inspection process.

We received mixed feedback from both the registered manager and local contracting professionals in relation to how the provider worked in partnership. The registered manager told us that Olive Home Care & Support had decided to no longer work with one local authority. The registered manager felt that communication with the local authority was poor. One contracting professional fed back that they had implemented an action plan to address significant issues identified during site visits with the service's operational systems. The key shortfalls discussed in the action plan included, supervision and administrative support to enable the registered manager to manage the service effectively, the management of missed and late calls and the management of the administration of medicines. They confirmed these issues had the potential to impact negatively on service delivery standards and that the progress demonstrated by the registered manager at the end of the review period fell well below the standards required in the action plan. Another contracting professional confirmed that communication with the service had been poor and that reports in relation to safeguarding's were delayed. They believed this was because at times the registered manager was providing direct care cover and that they had difficulty retrieving information from the electronic system. They also told us that the provider had been present during some meetings but had not always demonstrated an awareness of their own responsibilities. This is an area that needs improvement.

There was a policy in place in relation to the Duty of candour and the registered manager was aware of their responsibilities under the Duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

The registered manager and staff told us they worked closely with health professionals such as the local GP's and health rehabilitation specialists when required. One social care professional who had limited

contact with the provider in relation to one person's capacity told us, "The registered manager was very responsive during our initial contact, they gave the impression they were aware of the level of risk."

The registered manager and Provider Information Return detailed that the service had established a community presence through being situated in the centre of the town, advertising in local churches, engaging with local day care services and taking part in fund raising activities coffee mornings for a local charity. The service also offered work opportunity experience for local students.

Satisfaction surveys involving people and relatives were completed in April 2018, which provided people and relatives with an opportunity to feedback about the quality of care provided within a given format. The survey outcomes were positive. People said they were receiving the care they expected. One person described that they couldn't read their care plan, but their daughter read it and overall, they were happy with the service. Where feedback detailed some lessons to be learnt for example a change in carer, people's wishes were respected and the change made.

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 (1) (2)(a)(b)(c) The provider had not ensured people were provided with safe care and treatment required to meet their assessed needs, or which reflected their preferences. The shortfalls in the administration of medicines and the deployment of staff resulting in missed or late calls placed people at the risk of harm

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (2)(3) The provider had not always ensured that service users were protected from abuse and improper treatment by identifying safeguarding concerns and ensuring their own systems, processes and practices to protect people's rights to be safe from the risk of potential abuse and harm were carried out

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed (1)(2)(3) The provider had not always ensured that the people employed to carry out regulated activities were of suitable conduct to work with

vulnerable people

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1)□(2) (b)(c)(f) The provider had not always ensured that they had quality systems and processes that robustly assessed, monitored and mitigated risks relating to the health and welfare of people using the services

The enforcement action we took:

We have issued a Warning Notice as the Registered Persons had not ensured that they maintained good governance. The registered persons are required to become compliant by 17 December 2018