New Hope Specialist Care Ltd

New Hope Care Coventry

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

New Hope Care Coventry is a domiciliary care agency which is registered to provide personal care support to people in their own homes. At the time of our visit the agency supported approximately 49 people with personal care and employed 14 care workers.

We visited the offices of New Hope Care Coventry on 17 November 2016. We had told the provider 48 hours before the visit we were coming so they could arrange to be there and arrange for care workers to be available to talk with us about the service.

This was the first inspection of New Hope Care Coventry at this location.

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. The registered manager was not available on the day of the inspection. The inspection was supported by the deputy manager and the provider's nominated individual who was present for most of the office visit.

Prior to this inspection we had received concerns from care staff and commissioners of the service about late and missed calls, staff recruitment practices and staff not being paid. We were able to look at these concerns during our inspection.

We found the service provided was not consistently safe. Not all care workers understood how to recognise abuse or how to report safeguarding concerns. Risks associated with people's care had not always been identified and there was no information for staff to follow about how some identified risks were to be managed safely.

Documentation to show staff had been recruited safely was not available for all care workers employed by the service. Where agency staff had been used to cover care worker absences there was no evidence to show these staff had been properly checked and trained before providing care to people.

Care workers told us they completed training to provide the care people required but some said the training they received had been very basic. Most care workers we spoke with had little understanding about the training they had completed and were unable to tell us how they put some of their training into practice.

The deputy manager had an understanding of the principles of the Mental Capacity Act (MCA) and their responsibility under the Act. Most care workers we spoke with had no understanding of the Act and how this affected their practice. However, people told us care workers asked for their consent before providing care and respected any decisions they made.

Managers and care workers told us there was sufficient staff to provide all the scheduled calls to people. However, we were told there was no capacity to cover staff sickness and staff work rotas showed some care workers worked very long hours without any time off.

People told us they had regular care workers who stayed long enough to provide all the care and support they required and had time to sit and talk to them. Most people said the times care workers arrived had improved recently and they now arrived around the time expected. Although some people told us they had experienced late calls.

Most people felt involved in their care and care plans provided guidance for staff about how people liked their care delivered. Care workers knew how people liked to receive their care and had time to read their care plans. People told us care workers were kind and respected their privacy and dignity.

Care workers received support and supervision to carry out their roles which included regular observations of their practice.

People knew how to complain and information about making a complaint was available for people. Care workers said they could raise any concerns with the office staff, knowing they would be listened to and acted on.

The provider had processes to monitor the quality of the service and understand the experiences of people who used the service. This included reviews of people's care, satisfaction surveys and checks on records returned to the office. There was a programme of other checks and audits to monitor and improve the service. The procedure to check records had been completed but was not robust, as audits on records returned to the office were not always accurate.

Staff in the office told us they felt under pressure as the provider's auditing systems were not consistent. Several staff told us morale was poor and that they didn't feel valued by the provider as they were not always paid in full when expected.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 were not always protected from the risk of abuse as some care workers were not aware of what constituted abuse or how to safeguard people by reporting concerns. Risks associated with peoples care were not always identified and the staff recruitment process was not always robust. There were sufficient care workers to provide all the scheduled calls to people. People said they received their medicines when they should have them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a training programme for staff but most care workers we spoke with had little understanding about the training they had completed. The management team understood the principles of the Mental Capacity Act (MCA) but some care workers did not know what this was, or how it should be put into practice. People who required support with their nutritional needs had sufficient to eat and drink and the service involved other healthcare professionals to maintain people's health and wellbeing.

Is the service caring?

Good

The service was caring.

People received care and support from care workers who they knew and who understood their individual needs. People told us care workers were kind, caring, and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Most people said they now had regular care workers that mainly arrived around the time expected. People's care needs were assessed and people received a service that was based on their personal preferences. Care plans were reviewed and care

workers were given updates about changes in people's care. People knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems to monitor and review the quality of service people received, however these were not sufficiently robust to ensure the service was always safe and effective. Care workers received support and supervision to carry out their roles, but did not always feel valued by the provider. People were satisfied with the service they received and felt able to contact the office if they had any concerns.

New Hope Care Coventry

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The office visit took place on 17 November 2016 and was announced. We told the provider we would be coming so they could make sure they and care workers would be available to speak with us. The inspection was conducted by 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.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and in the statutory notifications we had received during the previous 12 months. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We had received some concerns from commissioners about the service that we reviewed during our inspection.

Before the office visit we spoke with 11 people (six people who used the service and five family members) by phone. During our inspection visit, we spoke with the provider's nominated individual, the deputy manager, a care co-ordinator, and four care workers. Following the office visit we spoke with another care worker by phone.

We reviewed five people's care plans and daily records, to see how their care and support was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

There was a procedure to identify and manage risks associated with people's care but we found this had not been consistently implemented. Not all identified risks had been identified and plans put in place to manage the risk. Where plans were in place these were not always accurate and did not always provide care workers with sufficient information about how to manage the identified risk. For example, one person required food supplements to be administered through a percutaneous endoscopic gastroscopy (PEG) tube. A PEG is a way of introducing nutrition, fluids and medicines directly into the stomach when a person has difficulty swallowing. We found instructions about how to manage the PEG was not sufficiently detailed for care workers to manage the PEG safely. The recorded information was, "Before I get up care staff to feed me via the PEG tube. In the morning I have one fortisip, (food supplement)." There were no instructions for staff about how to care for the PEG site or how to manage the tube by flushing this through with a specified amount of water before and after the food supplement to ensure it did not become blocked.

In another care record we saw the person was prescribed medication for epilepsy. There was no information in their care plan about this condition. The Social Service referral stated the person was at risk of epileptic seizures. This information had not been transferred to their care plan and there was no risk assessment to inform staff how to manage any seizures. We discussed this with the deputy manager who was aware the person had epilepsy, but said the person had not had a seizure for many years. This was not consistent with the information recorded in the referral.

Another person's care plan told us, "At the moment I need to be hoisted out of bed to mobilise, however I don't like the hoist and I am staying in bed throughout the day." A bed mobility assessment had been completed but this contained conflicting information. The risk assessment had four sections "turning in bed, moving up/down bed, sitting in bed and getting in/out of bed". Each section stated that the person required two carers to support the person but the comments for each said "[Name] is able to do this independently," which was incorrect. This person also had ulcerated legs and the district nurse visited to change dressings. There was no risk assessment about how to manage the person's skin, or body map to show were the skin was damaged.

In another care plan the person required a hoist to transfer in and out of bed but there was no risk assessment for moving the person safely.
Care records did not always provide staff with information about people's medicines, for example in one person's records which stated, "Staff required to administer medication," there were no details in the care plan about what medicines were prescribed, what they were for, or any risks from taking medicines.

People were not sufficiently protected from the risks associated with their care to ensure their safety at all times.

We found one risk assessment that had been completed correctly and provided clear instructions for staff about how to keep the person and themselves safe. We used this as an example of completing a risk assessment during our feedback to the deputy manager. However, the risk assessment had not been

reviewed for over a year, so we were unable to assess if this assessment was still accurate and up to date.

This was a breach of Regulation12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

Prior to the inspection we had received concerns about the provider's recruitment practice, which we shared with the local authority commissioners and the provider. The provider sent details to us about how care workers recruited from overseas were checked to make sure they were safe to work with people who used the service. The provider had recruited staff using an agency based abroad who had carried out pre-employment checks, which included a police check valid for six months. Once care workers arrived to work in the UK, they completed an application form which included two references, as well as providing proof of identity and right to work documents. After six months in the UK the provider completed a Disclosure and Barring (DBS) check, to check people's backgrounds for criminal records and to see if there were any restrictions to work with people who used the service. We found these procedures had not been implemented consistently or thoroughly.

We looked at six staff recruitment files; four were for staff recruited from overseas. Application forms had not been fully completed; forms did not provide a full work history or contact details for references. In three of these files we found references had been provided by other care workers who worked for New Hope Care, and in two files these people were also listed as the person's next of kin. In one file both people recorded as referees had only known the person for two months. One file contained a copy of a police check undertaken overseas, dated 17 December 2015 valid for six months. There was no confirmation that a DBS check had been completed by the expiry date in June 2016. We discussed this with the deputy manager who advised there was a separate file for DBS certificates which was provided for us. There was no DBS found in the file for this member of staff although the deputy manager was certain one would have been completed. There was a tick list in staff files which included right to work details. Although the person's right to work had been recorded on the tick list there were no copies of the documents to show this was correct and the person had right to paid employment.

Prior to our visit we had been informed that New Hope Care Coventry used a staffing agency to cover care workers absence. The nominated individual told us the staffing agency had been supplying agency workers on a regular basis but they had now stopped using the agency. They said the last time they had used the agency was the previous week, Friday 18 November 2016. We asked what proof was obtained from the agency to ensure their care workers had been recruited safely and had completed the training required to deliver the care people required. The nominated individual told us they had no documented proof to evidence this.

We found documents were not always completed or available to evidence safe recruitment had been fully implemented to ensure staff employed were suitable to work with people who used the service.

This was a breach of Regulation19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed).

Prior to the inspection we had received concerns from care staff and commissioners of the service about late and missed calls to people. We spoke with 11 people who used the service, or their family member, before the office visit. People had mixed experiences. Some people told us staff arrived around the time expected while others had experienced late or missed calls. People who had experienced late calls told us this was several weeks ago and that timing of calls had recently improved. People's comments included, "They mainly arrive on time, sometimes a little late. We had one occasion where they didn't turn up at all

and didn't let us know which we weren't very happy about, but we raised this with them and it's been ok since." And, "We have had occasions recently (6-7 weeks ago) where they hadn't turned up for the evening visit. We rang the office and they kept saying they would be there in 30 minutes … we had to keep ringing they were due at 7.30pm and arrived at 9.30pm."

Other people told us, "They [care workers] are not late, if they are it's only ever by a few minutes. I'm sure they would let me know if they were going to be late, but it's never occurred." And, "They arrive on time more often than not and if they are running late they will let me know."

The nominated individual, deputy manager, care co-ordinator and care workers we spoke with all said there were sufficient care workers to allocate all the calls people required. The deputy manager and care co-ordinator went on to say , although there was enough staff to cover calls to people they were unable to take on any new care packages and that it was a struggle to cover staff sickness. The provider told us they had used a staffing agency to provide care workers to cover absences, they went on to say they were no longer using this agency.

We looked at how calls were scheduled to people and requested a copy of staff rotas. This showed calls people required were allocated to regular care workers at specific times and included detail of the length of time allowed for the call to take place. Care workers were allocated the same people to visit regularly. Although we noted some care workers worked very long hours without any time off. We spoke with one care worker who worked long hours; they told us it was their choice to work this amount of hours.

Care workers were provided with 24 hour support from senior staff. The provider had an out of hour's on-call system to support staff when the office was closed. One care worker told us, "I have used the on call when I needed help or advice it works fine." Care workers told us there was always someone available if they needed support.

People and their relatives told us they felt safe with their care workers, they told us, "Yes I feel very safe with them they are all very nice." "Yes I feel they are very good, I feel that [relative] is safe with them." "I do (feel safe) now I have the same carers." People knew what to do if they had any concerns about their safety. All the people we spoke with said they would contact the office if they didn't feel safe.

The provider had a safeguarding policy and procedure to protect people from harm. This included safeguarding training for staff so they knew how to protect people from abuse. However, not all the care workers we spoke with knew how to recognise abuse or who they would refer safeguarding concerns to. When asked about abuse three care workers had no understanding about abuse. One care worker told us, "I don't remember exactly what the types of abuse are." Asked if they could give examples of abuse, another care worker said, "I don't know." This meant people were not always protected from risk of abuse as some care workers were unable to recognise if abuse was taking place. The provider and deputy manager understood their responsibility for reporting any safeguarding concerns to the local authority safeguarding team and to us.

Some people used equipment to help them move around or to transfer in and out of bed. People and relatives told us care workers knew how to use the equipment and transferred them safely. Comments from people included, "I have a hoist, the staff know how to use it." "I need a hoist the regular carers know how to use this, the newer ones I have to tell them what to do." And, "I have a wheelchair I can transfer myself, though when I came out of hospital I had a hoist the staff were very good with equipment." A care worker told us, "I've had training on all the hoists. I know what hoist to use and how to handle it. It's in the care plan and you can ask the person."

We looked at how medicines were managed by the service. Most people we spoke with either managed their own medicines or had a relative to support them with this. Where care staff supported people to manage their medicines it was recorded in their care plan. Five people we spoke with were supported to take medicines all said care workers gave these as prescribed.

Care workers told us, and records confirmed; they had received training to administer medicines and had been assessed as competent to give medicines safely. Care workers recorded in people's records that medicines had been given and signed a medicine administration record (MAR) to confirm this. Completed MARs were returned to the office monthly for auditing. We found the process for checking medication records returned to the office was not sufficiently thorough. This was because errors on MARs had not been identified when they had been returned to the office and checked. We have asked the provider to improve this.

Requires Improvement

Is the service effective?

Our findings

We asked people if they thought staff had been properly trained to look after them. People thought they were, but said new staff were not as good. Comments included, "I think the staff that have been here a while are properly trained I have my doubts about the newer staff." And, "Definitely the ones that have been here a while are. I'm not so sure about the new ones."

We spoke with five care workers about the training they had completed. This was a mixture of new and more experienced workers. All said they had received an induction when they first started with the service that included working alongside experienced workers and training to carry out their role. Care workers told us, "I had four days induction training and shadowed for two weeks." We looked at six care workers files, we saw an induction check list on files but most of these had not been fully completed or signed off. There was no evidence to show the induction care workers received was linked to the principles of the care certificate. In one file we saw a certificate titled 'Care Certificate' but there was no evidence to show the care worker had completed the modules to support the certificate. The Care Certificate is a set of specific standards which, when completed, should provide care staff with the key skills, knowledge, values and behaviours to provide high quality care and support.

We asked care workers if the training they had completed supported them to do their job. Care workers told us about the training they had completed which included moving and handling and medication training. Two care workers said they were working towards national vocational qualifications. One care worker who had previous experience of working in care told us they had completed all the required training but the level was very basic compared to their previous training.

During our discussions with care workers we asked about aspects of the training they had completed. Three of the five care workers were unable to tell us in any detail about their learning and how they would put their training into practice. They were unable to tell us what constituted abuse, or what to look out for to show a person may be at risk, and had no understanding of the Mental Capacity Act, what this was or how to put this into practise. Four of the five care workers we spoke with had no previous experience of working in a care service, and three were unable to demonstrate they had gained the skills or understanding from the training to provide the care people required in a safe way.

We asked for a copy of the staff training matrix this showed staff had completed all the training the provider considered essential to work with people who used the service. However, training records and certificates on staff files we viewed were not always consistent with the training matrix. For example, there was no evidence in two files to show the care workers had completed medication or safeguarding awareness training. In some files we saw recent certificates that showed staff had completed multiple training courses in one day. For example certificates titled 'Mandatory Training' dated 5 May 2016 listed six topics and 6th May 2016 listed seven topics. Over two days the staff members had completed 13 training courses. These included a range of diverse and different topics, such as Moving and Handling (both practical and theory). Mental Capacity Act, and Safeguarding (vulnerable adults) training.

We had concerns about the quality of the training and the knowledge and understanding care workers would gain from completing so many courses in such a short period of time. We would expect the provider to ensure the induction and training care workers received fully equipped and supported them to provide the care people required. This was further evident from our discussions with the care workers.

This was a breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

We asked the deputy manager about staff learning and understanding of the training completed. They were aware care workers retention of information, and understanding of the subjects they had received training in was very limited, especially where care workers first language was not English. The deputy manager told us they had arranged individual meetings with some care workers to reinforce their learning.

Care staff told us, and records confirmed they had regular supervision meetings to monitor their knowledge and learning and had 'spot checks' on their practice. One care worker told us, "I have supervision every 3 months, it is a one to one meeting and I have field observation every four months. They check my uniform and that I'm doing everything properly." The deputy manager told us during spot checks they looked to see if care workers followed correct procedures and training. They checked to see if they were dressed appropriately, read care plans and recorded what they had done during the visit. They said during observations they talked to the person about the care they received and asked them if they were satisfied with how the care was provided.

We checked whether the service was working within the principles of the MCA. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The deputy manager understood their responsibilities under the Act and told us most people using the service were able to make their own decisions. Where people required support to make certain decisions family members were available to help them do this. In one file we saw a capacity assessment had been completed when the person was referred to the service. We found the information recorded on the assessment was not consistent with the information on the referral from the local authority. A capacity assessment completed 15 September 2016 state the person had, "No impairment of brain function" however, the social service referral stated, "[name] has had a left cerebella haemorrhage which impacts on physical and cognitive abilities."

Three of the five care workers we spoke with had no understanding of the MCA and two care workers knew this was about people's decision making ability and gaining consent to provide care to people. One care worker told us, "I ask if they want a shower, I ask if I can wash their hair. They choose clothes". Another told us about a person they visited, "[Person's] family make decisions about his finances and health needs." "[Person] can make choices about his clothes; he knows what he likes and will pick what he wants."

Where family members supported people who lacked capacity to make decisions, for example to receive a care service or manage their finances, there were no documents on people's files to show they had the correct authorisation to do this. Several people remembered signing their care plan and giving consent to the service to be provided.

People and relatives told us care workers asked for consent before they provided care. One person told us, "Yes they always make sure I'm ok with everything," and a relative said, "Yes they make sure [family member's] ok with what they are doing."

Several people we spoke with said care workers supported them to prepare food and drinks. People and relatives told us staff offered a choice from the food they had available and prepared food in the way they liked. People told us, "Yes usually a sandwich or microwave meal," and, "Yes they ask what I'd like." A relative told us, [Person] will only have cornflakes for breakfast and likes them a certain way but the staff know this now." There were procedures in place to monitor and manage people's nutrition and hydration if this was required to make sure people's nutritional needs were being met. For example one person required food supplements to be administered through a percutaneous endoscopic gastroscopy (PEG) tube. Care workers told us they had been shown how to manage a PEG. The deputy manager told us care workers had recently received training from a health professional to do this and they were waiting for their certificates. People said care workers left them with a drink before leaving. "They always ask if I need anything before they go and make sure I've got a drink if I want one" and "They make sure she has whatever she needs before they leave."

People who used the service managed their own health care appointments or were supported by family to arrange these. Relatives told us, "No we do that although I'm sure if she was under the weather when they arrived they would let me know," and "We do that although they will contact the district nurse if they need to."

Care workers said they would phone the office to let them know the person needed to see a GP or district nurse if they needed to, but would usually ask the family to do this. A care worker told us, "I would contact the pharmacist for medication and if anyone has tissue viability problems I contact the district nurse. Most people have family who help them with this." Records confirmed the service involved other health professionals with people's care when required including district nurses, occupational therapists and GPs. Where needed, people were supported to manage their health conditions and had access to health professionals if required.

Good

Is the service caring?

Our findings

We asked people if they thought care workers were kind and caring, everyone we spoke with said they were, using words such as 'absolutely' and 'definitely'. Comments from people included, "They are very caring especially the ones I see most often." "Yes I do, some are better than others though. We have two that come that are very good and very caring," and "Yes they are very caring."

People and relatives said care workers treated them with respect, with one relative saying, "Yes they do, [family member] has commented that [care worker] is very gentle with her."

Care workers maintained people's privacy and dignity when providing personal care. They told us, "I close the door; I close the window so they are not feeling cold. I put towels down so they do not slip." "I cover with a towel when doing personal care. I ask them before doing anything. We close curtains and the doors." People confirmed this happened, and said, "They always make sure I'm covered when getting washed and dressed where possible." "They are very conscious of maintaining my privacy," and "They treat her like they would treat a family member it is very nice that she has this relationship with them."

People's care records showed that preference for gender of care worker had been discussed and recorded. We were told that where requested, male care workers did not provide personal care to females who use the service. People we spoke with confirmed that if requested they only received personal care from female workers.

Several people we spoke with said they were very independent and only required support with showering and washing. Other people needed more support, and said the support they received helped them to remain independent. One relative told us, "The support they provide does help her to remain independent, in that she can stay in her own place."

People and relatives said care workers were friendly, did not have to rush and had time to sit and talk to them. They told us, "We always have a chat it is nice to have people to talk to." And, "Yes they have chats, she really enjoys that." "Yes they do [sit and chat] and this is really important for her." Care workers confirmed they did not have to rush people and had time to talk with them, a care worker told us, "Yes, we have a chat. Some people are lonely and wait for us; we talk about what's going on that day."

We asked people and their relatives if they felt involved in planning their care [family members care] and that their views about their care had been taken into consideration and included in their care plans. Most people said they were, with comments such as, "Yes I do, and they are much better at listening than my last provider." And, "I think as relatives we are more involved in the care, although we do always make sure that [family member] is happy with it."

We saw records in the office that contained personal information were secured and kept confidential. Care workers had some understanding of maintaining people's confidentiality. We asked care workers about making phone calls to the office if they needed to pass on information about people or get advice. One care

worker told us, "I make calls to the office, I phone from the car." Another said, "We keep all information private and safe. If I had to make a call to the office I would do it at the person's house, I wouldn't do it where other people could hear me."

Good

Is the service responsive?

Our findings

Prior to our inspection we had received concerns from staff and commissioners of the service about late and missed calls to people, and people said they did not have regular care workers. During our inspection people and their relatives told us this had improved recently and they now had calls around the times expected and regular care workers who they knew. One person told us, "We were having problems with them arriving late. My husband spoke to the office and they have been fine now. We wanted to have the same carer as well, and now we do it is much better." Another person told us they did have the same carers but, "I do also have a lot of new ones. I would prefer the regular ones as we have built up a good relationship."

People told us care workers understood their needs and knew their likes and preferences. People said, "They do, that's because I have the same ones now and we have got to know each other." "Yes, they have built up a good relationship with her," and, "Of course my regular ones do." Another person said "Yes they are like family."

Care workers told us they now supported the same people regularly and knew people's likes and preferences. One care worker told us, "Yes it's usually the same people they feel more comfortable when they have the same carers." People said care workers completed the tasks they expected them to before they left. We looked at recent call schedules for people who used the service and at the corresponding care workers rotas. These showed people were allocated regular care workers at consistent times where possible.

Care workers we spoke with had a good understanding of the people they visited and told us they had time to read care plans in people's homes. They said there was information in care plans to inform them what to do on each call and they were kept informed of any changes in people's care. One care worker said, "I usually go every day, four times a day so I know people. If there are any changes my manager would phone me if I didn't know, and it is written in the communication sheet. I always ask the person too." Care workers told us that any changes in people's needs were referred back to the office for reassessment. They said they were kept up to date with any changes with people's care through phone calls and visits to the office.

The service was responsive to people's needs. For example, during our visit the deputy manager answered a phone call from a person who used the service who told them there was a problem with their catheter. The deputy manager knew the reason for this and reassured the person they would get someone to call. The deputy manager immediately phoned the care worker who had visited that morning and asked them to prioritise another call to this person, they also phoned the district nurse to ask them to visit in case the catheter needed changing. The deputy manager then phoned the person to let them know someone was on their way.

We were told by the deputy manager they tried to be flexible to requests if people needed to change the time of calls. One person we spoke with told us this happened, they said, "My call in the morning is later than I would like but as I have only recently joined it was the only time they could come. They will try and come

earlier if I have an appointment or going somewhere."

We looked at five care records. Overall, care plans were person centred and provided care workers with information about how people wanted to receive their care and support. An individual needs assessment had been completed with details of what support the person needed at each call. For example; what personal care people required and their preferences in how they liked care provided. In one plan there were details recorded about which colour flannel to use to wash different areas of the person's body and detailed instructions about how to use the hoist. Ten of the eleven people we spoke with said they had regular reviews of their care and that their views were listened to and recorded.

We looked at how complaints were managed by the provider. People knew how to make a complaint, and felt confident to raise concerns if they needed to. They told us, "I would get in touch with the office or social services," and "Yes if I had to but I have never needed to." Some people knew there was information in their care folders about making a complaint, they said, "I think the information is in her folder," and "I'm sure there is [complaints information available]. I would contact the office in the first instance, and take it further if it wasn't resolved from there." People who had raised concerns said these had been resolved to their satisfaction, they said, "Only when we asked if we could have the same carers, everything has been ok since then," and, "Yes when we contacted them about not turning up and not letting us know, it hasn't happened again."

We looked at the record of complaints held at the office. Complaints and concerns received had been looked into and responded to in a timely manner. However, we found there was no overall record of complaints received, to show what actions had been taken in response to the concern, the outcome of the investigation and to monitor trends and patterns. The deputy manager told us they would discuss this with the registered manager and devise a log to record this information.

Requires Improvement

Is the service well-led?

Our findings

The service people received was not consistently safe, effective or well led. We found procedures in place did not always safeguard people from potential risks associated with receiving care. The risk assessment process had not identified all risks with people's care and where risks had been identified plans to manage risks had not always been completed. Although care plans were reviewed regularly these shortfalls had not been identified during the reviewing process or when care files had been audited.

The recruitment of staff was not sufficiently robust and audits of recruitment documents had not identified all the shortfalls we identified with the providers recruitment process.

Staff training did not provide all care workers with the knowledge and understanding to provide safe care to people. Some care workers were unable to tell us what constituted abuse and had no understanding of the Mental Capacity Act, even though they had completed an induction and training. We found training had not provided some care workers, particularly where their first language was not English, with the skills or knowledge to carry out their roles.

Records completed by care workers during visits to people were returned to the office on a monthly basis to be checked and audited. We found several errors on medication administration records (MAR) that had not been identified when they were audited. For example, three of the four completed MAR we viewed had unexplained gaps where no signatures had been entered to confirm people had received their medicines. Other than a record to show the care worker who had completed the MAR had used the wrong colour pen, the audit had not identified the errors. The procedure for auditing records returned to the office was not sufficiently robust to ensure people had received all the care they required.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance)

The service had a registered manager as required. The registered manager was newly registered with CQC to manage the Coventry location, but was already the registered manager for another of the provider's locations. We asked the nominated individual how often the registered manager visited the Coventry location. We were told the registered manager spent approximately two and half days a week at the location. However, the deputy manager and care co-ordinator said this was not happening. They told us the previous week the registered manager had only been at the Coventry office for part of one day, but they were available by phone if they needed to speak with them.

The deputy manager told us after the previous manager had left they had found the rota system for staffing was not effective and care files were not up to date. They said they had revised the staff rota system and updated all the paper work. They went on to say following an audit by the provider they had to change all the paper work again to be consistent with the provider's procedures. They told us the changes had been checked by both the registered manager and nominated individual to ensure the audit requirements had been implemented. The deputy manager told us implementing all the changes had taken a lot of hours and

work, but had resulted in people having regular care workers to provide their calls, and paper work was up to date. They were particular unhappy as they had a further audit from a different manager the week before our visit where they had been told they had not implemented the action plan as required and would need to redo most of the work they had completed. This inconsistency from the provider had an impact on the morale of the deputy and co-ordinator, as they told us that they felt undervalued and unsupported.

We asked if the deputy manager and care co-ordinator had regular meetings with the registered manager. They said they did meet informally, however nothing was recorded to show what had been discussed or if any improvements to the service had been put in place.
Care workers told us they had regular staff meetings organised by the deputy manager, where they could share their views and opinions. Eight people said they had been sent a questionnaire to see if they were satisfied with the service.

Care workers said they had regular supervision meetings to make sure they understood their role and spot checks to make sure they put any training into practice. A staff member told us, "I receive regular supervision [deputy manager] and [coordinator] are always available if you need advice." Six people we spoke with told us they remembered senior staff visiting to check on care workers and to see if they were happy with the care worker and how they carried out their role.
Most people thought the service was well led, and spoke positively about the deputy manager and the co-ordinator. Care workers told us they received good support from the deputy manager and co-ordinator. They told us, "I am well supported by my manager; she is always there to help me," and "I don't have any problems with my manager. I would speak to them about anything." All the people we spoke with said there someone available in the office if they needed to speak with someone, although one person said it was sometimes difficult to get through.

However, all but one of the staff we spoke with said they did not always receive their full wages each month, which made them feel undervalued by the provider. Staff said this impacted on their daily lives. The deputy manager told us problems with wage payments was affecting staff morale.

We asked the nominated individual about this and we were given assurance about the company's finances. We were told the problem with staff wages related to an oversight with the payroll that had been resolved. However staff told us they had experienced shortfalls in their wages at the end of October.

All the people we spoke with were happy with the service they now received, although two people said they would like to know in advance which care workers would be calling. They told us, "Yes I'm happy. I would just like to know who's coming on what day." and "I'm happy on the whole wish all the staff were as good as my regular ones."

We asked people what could be improved, one person said, "They are really good I don't know what they could do better. There is sometimes a bit of a language barrier with some of the staff as there are quite a few where English is not their first language." We also asked staff what could be improved, comments included, "Staff training, its very basic." Another said, "I don't think the training is sufficient to give us all the skills."

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 12.(1) (2)(a)(b) The procedures for protecting people from abuse and for assessing and managing risks to peoples care were not always sufficient to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17.(1) (2)(a)(b). Systems and processes to monitor the quality and safety of service provided, and to manage risks related to the health, safety and welfare of people, were not consistently implemented.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19.(1)(a)(b) (2)(a) Recruitment procedures were not operated effectively to ensure that staff employed were suitable to work with people who used the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18.(2)(a). Staff were not always supported to undertake training, learning and development to enable them to competently carry out of their role.