Nestor Primecare Services Limited

Allied Healthcare Bridlington

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 10 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

The service provides personal care to people who live in their own homes in the Bridlington, Driffield Hornsea and Scarborough areas. At the time of the inspection there were 208 people receiving care and support services from Allied Healthcare Bridlington.

There was a registered manager in place who was registered with the care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People were protected from abuse by care workers who had received training in safeguarding adults and understood the signs of abuse to look out for and how to report any concerns including whistleblowing if appropriate.

The registered provider undertook risk assessments to keep people and others safe whilst in their home. We saw that this information was not well documented or in sufficient detail to ensure care workers had adequate information to mitigate and manage risks to people.

Employees were recruited into the service with appropriate checks on their suitability. Care workers received a robust induction process and the registered provider put new staff through training in line with the care certificate to ensure they understood the fundamentals of delivering care and support. Mandatory training was well managed and some additional training was provided to meet people's needs. However, we saw that care workers worked with people with specific needs and at times, they had not received appropriate training to meet those needs. Deployment of care workers and the allocation of calls meant care workers often did not spend the full amount of time with a person and arrived late. Cover provided when care workers were away was not effective for people and we saw care workers did not always understand people's needs. This was a breach of Regulation 18(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People received assistance with their medication; the amount of assistance they received was dependant on their assessed needs. Care workers received appropriate training and competency checks. The registered provider had an audit procedure to check medication was well managed. However, despite this medication was not well managed or recorded and we saw a number of errors and recordings where it was not clear if a person had received their prescribed medication. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers received training in the Mental Capacity Act 2005 (MCA) during their induction and had a basic understanding of the principles. We saw the registered provider worked with the Community Mental Health team where they had concerns. Care plans identified where a person had fluctuating capacity but we saw that systems and processes that had been established by the registered provider did not contain sufficient detail regarding people's capacity to ensure care workers worked within the requirements of the Act.

The registered provider was in the process of updating care plans for people. Despite this process, we saw that care workers did not always have sufficient information available to them in care plans to provide person centred support and did not have access to important information about the person's individual needs and preferences. The information documented was not always transposed to the summary sheets and some areas had not been completed.

Communication between people, care workers and the agency office staff was not well managed and employees raised this as a concern.

Quality assurance systems and audits were in place and feedback from people had been sought using a questionnaire. However, despite the systems in place we found that these were not always effective in driving improvement or in managing risks for people using the service and employees. This was a breach of Regulation 17 (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was limited or sometimes no evidence to suggest people had been involved in planning or agreeing to the care and support provided and people's ability to make decisions was not clearly recorded. This was a breach of Regulation 11 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had an effective process and systems were in place to monitor and respond to complaints and compliments. We saw these were handled effectively and led to improvement in people's care and support.

Communication between people, care workers and the agency office staff was not well managed and employees raised this as a concern.

Quality assurance systems and audits were in place and feedback from people had been sought using a questionnaire. However, despite the systems in place we found that these were not always effective in driving improvement or in managing risks for people using the service and employees.

We identified four 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 always safe.

Care workers knew what signs of abuse to look out for and understood how to raise their concerns.

The registered provider had undertaken risk assessments for people in their home and environment. However, this information was not consistently recorded in people's care files to ensure care workers had adequate information to mitigate and manage risks to people.

Medications were not always managed effectively and although procedures were in place to monitor the process these procedures were found to be ineffective.

Employees were recruited into the service with appropriate checks on their suitability.

There was sufficient staff employed by the service. However, staff deployment was found to be ineffective and care workers were not always able to meet people's specific care needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider had a robust induction process that employees followed.

Care workers did not always have support with knowledge and training to provide care and support specific to people's individual needs.

Care workers had a basic understanding of the Mental Capacity Act 2005. However, records in regards to people's capacity were not always well recorded and lacked detail.

There was a lack of evidence to demonstrate that people had been involved in planning or agreeing to the care and support provided and people's ability to make decisions was not clearly recorded.

People were supported to access other healthcare services to ensure they received holistic care and support suitable for their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Care workers were caring but did not always have sufficient information available to them in care plans to provide person centred support when providing cover for a regular carer.

The registered provider recognised and documented people's preferences about equality and diversity.

Care workers recognised the importance of treating people with dignity and respect in particular when providing personal care.

People were supported by advocacy and other professionals to understand and make important decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were centred on the individual but documented information was not always up to date despite recent reviews.

There was a process in place to monitor and review peoples changing needs and the service was responsive to concerns.

There was an effective process and systems in place to monitor and respond to complaints and compliments.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Management understood their responsibilities under their registration with the Care Quality Commission (CQC).

Audits and other quality assurance checks were in place but these checks were inconsistent and did not always bring about improvement.

People's views on the service had been sought in 2014. However, concerns highlighted during this process were still evident during our inspection.

Allied Healthcare Bridlington

Detailed findings

Background to this inspection

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

The inspection took place on 9 and 10 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection was carried out by one Adult Social Care Inspector. Before our visit, we looked at information we held about the service, which included notifications and information we had received from the local authority. Notifications are submissions of information to the CQC by the registered providers about certain changes, events or incidents that occur within the service. We did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we visited three people using the service and spoke with thirteen people by telephone. Four people were unable to provide feedback about the service over the telephone and we spoke with their relatives.

We visited the location's offices and looked at six people's care records, six recruitment and training records for care workers and other records used in the running of the domiciliary care service. We spoke with the registered manager, a field care supervisor and four care workers during our inspection and we spoke with a further five care workers by telephone during the week following our inspection.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us the service helped them to remain safe in their own homes. One person said, "I look forward to care staff visiting as I feel safer with them around." Another person told us, "I have a regular carer which is reassuring for me but it is different when they are away as I don't know who is coming."

Training records for care workers confirmed they had completed up to date safeguarding training and they understood how to identify and report their concerns. The registered provider had an up to date safeguarding and whistleblowing policy. We saw these included information about signs of abuse such as psychological, physical, sexual, emotional, financial, and female genital mutilation and exploitation of people by radicalisation. A care worker told us, "I wouldn't hesitate to raise any concerns and would follow the whistleblowing procedure if appropriate to do so." The care worker showed us details of the whistleblowing hotline on the back of their identity badges and told us, "We all have the number to hand so there is no excuse to ignore concerns."

Where care workers identified any concerns they had about people's welfare such as self-neglect, falls or refusing to take their medication, they documented the concern in an 'Early Warning Signs' (EWS) record. This was kept in people's files and was used to record any changes in people's health and behaviour so early monitoring and prevention measures could be implemented as appropriate.

People's care files we looked at contained a care plan, a summary of their individual needs and information to identify and manage risks. Risk assessments were in place for people's home environments and included; lighting, condition of paths, accessibility to property and risks associated with people's pets. This provided care workers with information to keep themselves and others safe when visiting people.

Other detailed risk assessments were undertaken as part of people's initial evaluation and included mandatory assessments and screening for skin integrity, nutrition, emotional wellbeing, allergies and slips, trips and falls. A summary section was included for care workers to quickly reference. However, we saw this information was inconsistently recorded and in some cases lacked appropriate information needed to guide care workers in effective risk management. For example, we saw one care file recorded a person had been assessed and it had been identified they had poor hearing and vision even when wearing glasses and using a hearing aid. However, the summary of the persons individual needs and care plan had no mention of this and the additional summary of risk assessments was completed with 'No risks'. We saw an assessment screening tool for another person included low moods, short term memory loss, behavioural issues, fluctuating mental capacity and an assessment that documented the person was out of breath walking. The associated 'Personalised care plan' and 'Personal Outcomes in relation to things that are important to me' had not been completed and 'No Risks' had been recorded. A care worker told us, "All the information should be in the file if the care plan has been reviewed."

The registered provider had a medication management policy in place and care workers had received in-house training on how to administer medication safely. The registered manager told us, "Care workers receive comprehensive training and shadow a care coach before being allowed to work independently with

people" and "We audit the Medication Administration Records (MAR) and if we find errors we bring care workers in for refresher training." They also told us, "Care workers are taken off medication administration until we are happy they are competent in the process."

We reviewed MAR charts used by care workers to record medication in a person's home. We found the MAR chart in use contained errors and omissions where staff had not signed to record that they had given the person their medication as prescribed. It was not clear if some medication had been administered on some occasions. A cream had been prescribed as, 'apply to affected area three times a day' but we saw the MAR had not always been completed to confirm this. We asked the care worker if they had additional information on what the cream was for or where it should be applied; they told us, "There is no other information, we ask [person]." Creams are applied to the part of the body being treated and are only effective on that part of the body. We checked the care plan and the MAR chart and there was no additional information or guidance, such as a body map, to direct the correct application for care workers. This meant insufficient information was available for care workers to administer medications safely.

The MAR chart detailed a medication with instructions to 'use as directed.' The care worker was unsure of what the medication was or where it was in the person's home. We saw from the registered provider's medication policy that they had documented, 'medication labelled, 'as directed' is unacceptable,' and 'written confirmation of the intended instruction should be obtained from the prescriber and recorded in the care plan.' We checked the care plan and we were unable to locate the additional information for this medication. The care supervisor told us, "Medication is a real problem; the process put in place by the local authority puts a great deal of responsibilities on the care worker." Care workers told us, "We have robust training but you still have to be very attentive" and "Medication is a nightmare, the process is too complicated and time consuming and not all care workers take the responsibility they have with re-ordering medication as it runs out so a person is always at risk of running out; especially if it's over a weekend."

In one person's home, we found completed MAR charts dating back to January 2016 and completed logbooks dating back to February 2016. We saw they had not been completed correctly. We spoke with the registered manager about our concerns. The registered manager undertook an investigation during our inspection. They told us the MAR charts and logbooks should have been returned to the office for audit. They said, "As a result of the concerns you have raised and our investigation, we have identified that eighteen care workers have been identified as incorrectly recording the administration of medication and they have been requested to attend medication training at the end of this week."

Despite the robust policies, training, competency assessments and audits that the registered provider had in place to mitigate risk to people, we found those processes and systems to manage medications in a safe way for people were ineffective. Accurate and complete records had not been maintained and the registered provider had not robustly assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files for six care workers. We saw that the dates references and Disclosure and Barring Services (DBS) checks had been received were recorded. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. It was clear on records that these checks had been undertaken and that the registered provider had received this information prior to the new employees being allowed to work independently with people.

We looked at staffing levels and we saw there was sufficient care workers employed. The registered manager told us they had no problem with the recruitment of employees and did not need to source staff from

employment agencies. They said, "If we are really short staffed then office staff are trained and they can and do cover calls." A person receiving a service told us, "It is ok when the regular staff are here but when they are off I don't know who is coming and the times all change" and, "My regular care worker is off this week and I haven't even had my list of who's coming yet." The care supervisor told us, "[Person's] regular care worker is off this week and the cover staff has not brought [Person] a copy of the revised rota for the week." A person's relative we spoke with said, "We have a few regular carers, weekends are a nightmare and we are never informed when a care worker is running late."

Feedback from care workers highlighted their concerns that staff rotas did not provide enough travel time and that they were expected to undertake excessive amounts of calls in one day. They told us if they were running late and informed the office, the information was not always communicated to the next customer and others on their rota. They said staffing was a problem due to sickness, holidays and turnover and cover was not always suitable to meet people's individual needs. The registered manager told us, "Excessive amounts of calls concern me as no one has brought this to my attention", they continued, "Availability is given by the care workers and we arrange calls within this; no care worker has raised this as a concern to any coordinator or at staff meetings or their supervision's but I will contact all and see if this is the case." They also told us, "Travel time is being reconsidered and we do pay travel from postcode to postcode for all workers."
This was a breach of Regulation 18(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed completed accident and incidents forms and saw that appropriate action was taken in response to the identified concerns. We saw these were assigned to the registered manager to review, identify any actions that needed to be taken and were signed off once they were satisfied with the outcome. The registered manager told us, "The system is robust and accidents and incidents cannot be signed off until everybody is happy with the investigation and outcome and that includes head office."

Requires Improvement

Is the service effective?

Our findings

The registered provider had a robust induction process in place for new employees. We looked at the training files for six care workers. We saw care workers had completed a five-day induction to the service. The registered manager told us "Everybody undergoes the induction." They said, "We employ some people with considerable experience but it is important they are inducted into our organisation and as an incentive we pay those people to take the training." A care worker we spoke with told us, "The induction is good and includes an introduction to the organisation and the basics of providing care."

Training which the registered provider deemed to be mandatory included fire prevention, food hygiene, health and safety, infection control, moving and handling, safeguarding adults from abuse, basic first aid and management of medication. We saw this was managed electronically. The system would not allocate a rota and care workers were unable to commence their duties until this was completed. We saw other training was available to care workers, which included dementia awareness. The registered manager told us, "If care workers identify they need specific training to meet a person's individual needs we will always try and provide it."

The registered manager told us they provided care workers with training to make sure that they had the right set of skills, competencies and qualifications to meet people's individual needs. We found that training specific to people's needs was not always available. We spoke with a care worker who told us a person they provided care for sometimes displayed behaviour that was challenging. They told us they had some understanding from previous employment on how to manage the behaviour but that they had not been offered additional training by the registered provider. Another person we spoke with had Parkinson's disease. The person told us that although they were happy with the care workers who visited they said the care workers had not received awareness training in Parkinson's disease and they said those care workers did not always understand their needs. The person said, "On one occasion I was experiencing 'freezing' and couldn't move very well, the care workers didn't understand what was happening." Many people with Parkinson's disease will experience 'freezing', which can be a common symptom where the person may find it difficult to move. This meant the registered provider did not always ensure care workers received the appropriate training to make sure they could meet people's care and treatment needs.

The registered manager explained how care workers were supported in their roles. For example, after induction care workers were supported by a 'carer coach'. This was a member of staff with specific skills in mentoring staff to become confident in their role. A carer coach we spoke with told us, "There really is no time limit on how long we coach people for," they said, "It is important they are confident in their roles." The registered provider showed us a distance learning workbook that all new employees would be completing as part of their induction. This document followed the standards of The Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. This demonstrated how care workers were supported to understand the fundamentals of care. It assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care.

The registered manager told us all employees were kept up to date with best practice and had their competencies and development regularly appraised and supported. They told us care workers had a unique access to an electronic database called, 'My connected'. The database provided staff with up to date information that included the registered providers policies and procedures. In addition, they told us that staff had an appraisal, supervision and two spot checks on their practice each year. Staff we spoke with confirmed that they had supervisions and that spot checks were completed. Staff files we looked at confirmed this was the case. We saw annual appraisals were also in place but that these were not always completed. A care worker told us, "Supervisions are ok, they give me a chance to air my views and my progress is discussed."

Care workers we spoke with had a limited understanding of the Mental Capacity Act 2005 (MCA). They told us, "It's to ensure people can live safely," "It's to do with people who have dementia," and "It is people's rights to make their own decisions." The registered manager told us "Staff receive an overview [of the MCA] during their induction but we don't provide specific training" and, "Where people's capacity is under question we work with the local authority 'Community Mental Health team' to address those concerns." The registered manager showed us a copy of a policy that covered the five key principles of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as 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. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA and found that, where they had concerns regarding a person's capacity they had worked with the local authority and appropriate referrals had been made. However, we saw from one care plan a person had been documented in the assessment screening as having 'fluctuating capacity.' The care plan had not been signed by the person to provide their consent to care and treatment and the information was not available to care workers on the summary sheet. We saw the local authority had undertaken a review with the person in October 2013 and in January 2015 that documented some 'mental confusion' by the person. However, despite risk assessments in the person's file for other areas of care and support, we did not see how information regarding the fluctuating capacity or detail of any triggers for this were documented or being managed and regularly reviewed by the registered provider. This meant information was not clearly documented to support care workers in carrying out their duties with the person. This was a breach of Regulation 17(2) (c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Other care plans we looked at did not consistently record that people had been involved in the decisions made about the care and support provided. We saw that consent to the care and support detailed in people's care plans was not always signed. One care plan contained the acronym 'CUTS'. We asked a member of staff about this and they said it meant 'client unable to sign.' We saw there was limited or sometimes no evidence to suggest people had been involved in planning or agreeing to the care and support provided and people's ability to make decisions was not clearly recorded. This was a breach of Regulation 11 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people receiving a service had an initial 'personalised individual nutrition risk assessment' to establish nutritional risk using measurements to obtain a score and a risk category. We saw that if the person was deemed at risk then additional information could be completed to provide care workers with information required to help people maintain a balanced diet. One person told us, "The care workers prepare my food and I tell them what I want to eat." Another person told us, "They [care workers] do help

prepare my food." Despite this, we found that there was sometimes limited detail or guidance for care workers and care plans did not consistently contain person centred information about people's food likes and dislikes or their nutritional requirements.

The registered provider had systems in place to ensure that people were supported to access healthcare services where necessary. Care plans contained information about people's health needs and contact details of health and social care professionals currently involved in providing care and support for them. People confirmed care workers called a doctor if they felt unwell, one person said, "I can ring the doctor myself but care workers are good at helping me to arrange any appointments I may need. Care workers told us they would report any concerns to the office and they would document information in the daily care logs. A care worker told us, "You get to know people and you know when they are under the weather."

Requires Improvement

Is the service caring?

Our findings

People using the service gave us mixed views of the care they received. Comments included, "They [care workers] are lovely and so helpful," and "It's ok when you get to know them but when they are new, I never know who is coming."

We spoke with a field care supervisor who told us, "New care workers shadow experienced people before they are given their own rotas." They continued, "Once they have passed their induction and are deemed competent they then go out on their own and they have support using their phones and can speak to the office; they are not introduced to their clients." We asked care workers how they got to know the history, needs and preferences of people they provided care for. One care worker told us, "Information is in available in the care plans but they are not always updated and we often only have half an hour with a person which isn't long enough to read their full file." Another care worker told us, "Sometimes when we commence a new care package with a new person we don't always have much information when we get to the home; but the office does provide a 'crib sheet' with basic information." We were told by care workers that they were not formally introduced to people at their first visit. A care worker said, "Our first contact with a person can be without any information about them; it can be concerning especially if they had dementia or something similar as we may not initially know that" And, "It is not always nice for the customer if we spend most of the first call with them reading their care plan when we should already have an idea of their needs; it can be very uncomfortable for both of us."

One person we spoke with told us, "In general care workers are very good and do support me but there was an occasion when I was getting dressed and wasn't ready to take my medication and they [care worker] left and didn't return." Further comments we received included, "Care workers are very supportive, I rely on them as I don't want to have to move into a residential home," and, "They [care workers] don't have enough time and are very task focused." We spoke with the care worker in the persons home about this and they told us, "Some care workers just administer [person's] medication and then they leave," they said, "There are always other things to do for example the washer may need emptying, the kitchen cleaning and pots to wash; it doesn't take half an hour to administer the medication." We spoke with the registered manager about this and they told us care workers should follow the care plans and checks were made to ensure they stayed for the full duration. Where a care worker left a call early, this should be documented in diary notes and followed up with the office staff. We looked at diary notes and did not see at the time of the inspection where this information had been documented.

We observed care workers were kind and compassionate when carrying out home visits. Care workers understood people's diverse needs. A care worker told us, "Its important people are treated as individuals and that they are supported, we aim to keep them in their homes and living independently." We observed care workers knocking and awaiting a response before entering people's homes. Care workers spoke with people in a dignified way and did not appear to be rushed when talking to people in their homes. People had their privacy and dignity respected by care workers. A care worker said, "I always make sure people are happy with the care I provide and that includes personal care such as bathing." They continued, "I always make sure towels and dressing gowns are available so people can be covered and if it is safe to do so I ask

them if they want some privacy and will wait just outside the room."

The registered provider had a confidentiality policy. Care workers told us they understood how to maintain people's confidentiality. A care worker told us "I never discuss people I care for with other people." They continued, "If they raised something that wasn't right, then I would discuss it with them and advise them that I may need to report it, in particular if it was a safeguarding concern."

Discussions with care workers revealed that where people receiving a service had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation the information was documented in their care plans. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

One person who used the service told us they had the use of an advocate to help them with their day-to-day decisions. We asked the registered manager about advocacy services. They told us, "We work with individuals and the local authority and where we feel someone may need support [to make specific important decisions] we involve advocacy services." An advocacy service is provided by an individual who is independent of the provider and social services and who is not part of their family or friends. Advocates support individuals, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them and will make sure the correct procedures are followed by the registered provider and other health professionals.

Requires Improvement

Is the service responsive?

Our findings

We received a mixed response when we asked people if the service was responsive to their needs. One person told us, "They [care workers] only have half an hour but they get a lot done to support me around the home." Another person told us, "I have care workers every day, they spend 35 hours a week with me and some are better than others at meeting my needs." A care worker told us, "I try and go over and above what is written down for people, just as though they were my family," they continued, "I am often told I do too much for [person] but I understand what it is like [for people]."

We saw that care plans were not always focused on the individual needs of the person being supported. Each person received an initial assessment to see whether the registered provider could provide the care and support that the person needed. Care files included demographic information that included how a person wanted to be addressed, religious beliefs and contacts.

People receiving a service had a care plan containing information about their needs. A copy of the care plan was stored in the person's home for staff to reference and a copy was stored securely in the location offices to assist in the planning of care packages. Care workers completed notes about the person after each visit in a daily logbook. This book included an 'early warning system' (EWS) that helped care workers to keep up to date with a person's changing needs and enabled management to identify any trends or concerns in order to respond accordingly. A care worker told us, "We complete notes after every visit so the next worker can read them and be aware of any concerns but we report anything serious to the office straight away."

The registered provider was in the process of updating the information they held on people in their care plans. The process gave the registered provider an opportunity for a structured re-assessment of an individual's needs and preferences and provided the opportunity for the registered provider to involve individuals and other people involved with their care and to provide detailed person centred outcomes. One person told us, "I have a new care plan, it was delivered this week; nobody came to go through it with me though." A relative told us, "I asked the office for a review of [person's] care last Christmas and was promised a new care plan would be in place back in February but nothing happened." We saw the person had a care plan in their home dated December 2014. A new care plan was brought to the person's home during the inspection and we saw the copy in the office contained up to date information. Whilst we saw most care plans had been updated to some degree we were concerned that where care plans had not been updated recently, or contained insufficient detail, staff would not have access to important information about that person's individual needs and preferences. The information documented was not always transposed to the summary sheets and some areas had no content. For example, we saw the section, 'personal outcomes, in relation to things that are important to me' had not been completed in any of the care files we looked at. We also saw some information was not always accurate and up to date. This was a breach of Regulation 17 (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they knew how to complain and who to speak with if they had any concerns. Care plans in people's homes included a welcome booklet containing information for people to use if they had concerns or needed to complain. One person told us, "I would complain if I needed to, but I haven't

needed to." A relative told us, "There is a complaints process and we know who to contact but it can be difficult to escalate problems when we need to." We looked at the 'complaint, incidents and accidents' monitoring system. This captured feedback in all these areas, recorded the details of any investigations undertaken and identified the actions necessary to resolve the issue in question. We saw a late call had been recorded and investigated. There was documented contact with the person's family, requests for information, an investigation and an outcome agreed. In this case, a change in call times had been agreed. The system was accessed by the company's head office, for the monitoring of outcomes. The registered manager told us, "The process for dealing with complaints is very robust and also includes compliments." We saw compliments were recorded and passed on to the care worker. The office had a 'rewards table' and staff could choose a reward from a selection of items because of positive feedback received. This showed that the service actively responded to concerns and compliments and that people's concerns were listened to with actions and outcomes recorded.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager was on duty and along with a senior support worker; they supported us during the inspection.

Management knew about their registration requirements under their registration with the Care Quality Commission (CQC) and were able to discuss notifications they had submitted. The Health and Social Care Act 2008 (HSCA) requires providers to notify CQC of certain incidents and events.

During our inspection we observed an efficient administration office with care workers, office staff and management interacting. There was a clear management structure in place and staff appeared to understand their roles and responsibilities. However, staff we spoke with gave us a mixed response about leadership and how the service was run. A care worker said, "Communication can be a problem, if I am running late and I ring the office there is one member of staff who doesn't pass on the information but it depends who you speak to." They continued, "I wouldn't feel comfortable approaching the manager with that particular concern so I always try and speak with someone else." Another care worker told us, "The biggest concern I have is communication, there is an employee in the office who does not pass on information and it affects the job we do and impacts on people's care and support." A relative told us, "Communication and management in the office is appalling, I requested that someone did not attend calls to my relative but nothing has changed." We spoke with the registered manager about this and discussed our observations during the inspection. The registered manager told us they were not aware of any concerns with communication and that they had an open door policy.

The registered manager completed a number of audits to check on the quality of the service. The registered manager told us these checks included monthly audits on daily record logbooks, medication administration records and annual care plan reviews. Despite the checks we found that records were not always well maintained and the system used to monitor the quality of records kept were ineffective. For example, we saw that there was not a robust system in place to ensure that MARs and daily logbooks were returned to the office and audited in a timely manner. By not ensuring these were returned to the office and audited in a timely manner, opportunities to identify and address concerns had been missed.

People's care plans were being reviewed at the time of our inspection but we saw that where they had been reviewed some lacked information to enable care workers to meet people's needs, preferences and keep them safe.

The registered manager showed us their most recent customer satisfaction survey dated 2014. The survey highlighted areas of suggested improvement. These included communication between office and customers that included communication when a care worker rings the office to advise they are running late. Communication was a concern highlighted during our inspection, which suggested the registered provider had not implemented effective changes to address this. The registered manager told us the location was changing its parent ownership and was awaiting the implementation of a new survey.

The registered manager showed us the feedback from a qualitative 'Carer Engagement Survey'. The survey was conducted over the telephone and asked care workers for their feedback on management, branch staff, the company, the Job and role, communication and general engagement with employees.

The registered manager showed us an electronic performance indicator. This gave the registered manager and senior organisational management 'at a glance' information on key performance areas, including areas that required improvement. This was monitored at board level and was part of the strategic approach used to identify and react to any trends and was used to help improve the service.

Despite the quality assurance checks in place, we found during our inspection that training and deployment of staff, management of medicines and care planning were being audited but we had concerns about these areas of practice. This made us question how effective the audits were.
We noted issues with the involvement of people in compiling and agreeing to their care plans. These areas were judged to have a minor level of risk to people using the service and a low impact on people's health and wellbeing.

Record keeping within the service needed to improve. We saw evidence that medicine records, care plans and risk assessments were not always accurate or up to date. This meant that staff did not have access to up to date and complete records in respect of each person using the service, which potentially put people at risk of harm.

Although the registered manager told us about a number of planned improvements, we found that records were lacking in information and not reflective of people's care needs. This was a breach of Regulation 17 (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was limited or sometimes no evidence to suggest people had been involved in planning or agreeing to the care and support provided and people's ability to make decisions was not clearly recorded. Breach of regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Processes and systems to manage medications in a safe way for people were ineffective. Accurate and complete records had not been maintained and the registered provider had not robustly assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. Breach of regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care workers did not always have sufficient information available to them in care plans to provide person centred support. Care workers did not always have access to important information about that person's individual needs and preferences. The

	information documented in care plans was not always transposed to the summary sheets and some areas had not been completed. Breach of regulation 17(2)(b)(c)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing was ineffectively deployed and there were insufficient numbers of suitably qualified care workers to meet people's specific individual needs. Cover when regular care workers were away was not well managed and lacked consistency for people. Breach of regulation 18(1), 18(2)