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1st React Healthcare - 1st React Healthcare Domicilary Care Agency

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 27 and 28 July 2016. The provider was given short notice because the location provides a domiciliary care service and we needed to make sure that someone would be in. Prior to the inspection we had received two concerns regarding infection control practices of care staff and people's dignity not being maintained. As part of this inspection we looked into these concerns. We found staff had received infection control training and were supplied with gloves and aprons which people said they used. People confirmed their dignity was maintained.

1st React Healthcare Domiciliary Care Agency is a small domiciliary care agency registered to provide personal care to people living in their own homes. The agency provides care to people living in Exmouth and the surrounding areas. The service is managed from an office in Exmouth which is easily accessible for people, relatives and care staff. The length of time of visits was variable and depended upon the needs of the person. For example one person received a 15 minute visit to support them with medicine administration whilst others received visits of one hour. The agency also provided some sleep in cover to support people in their own homes. The frequency of visits ranged from one visit a week to four visits a day. At the time of inspection, the agency was providing personal care to approximately 43 people and employed 29 care staff.

There was not a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run. The provider has a condition on their registration to have a registered manager in post. They have submitted an application to CQC to have this condition removed. This was because the agency has only a single location and the provider managed the service herself. The provider was supported by an assistant manager and a deputy manager. Following the inspection the provider made us aware that they had withdrawn their application to remove the condition of having a registered manager in post. They confirmed an application was being submitted for a new registered manager .

People and their relatives felt safe, cared for and supported by care staff in their own homes. They were treated with kindness and respect. However some people were not happy as they did not have consistent care staff especially during holiday periods. Where there were missed visits the provider took action to try and prevent the risk of this happening again. They informed people of changes by telephone calls and schedules being issued .

Staff were recruited safely. They undertook an induction and received training and worked with experienced care staff doing shadow shifts. However once new care staff had completed their induction they were not monitored and assessed to ensure they were delivering good care until they had their six monthly supervision and annual appraisals. Following the inspection the provider made us aware that they had made changes to improve staff monitoring and competency observations.

At their supervisions and appraisals staff had the opportunity to discuss concerns and any further training needs. Staff felt supported in their work. Staff meetings took place and staff felt communication was good at the service.

People's medicines were not managed in a safe and appropriate way. Improvements were required in how medicines were recorded to guide care staff to safely administer them. Care staff had not had their competence assessed to demonstrate they could administer medicines safely, which is good practice.

People had an assessment carried out when they started using the service. Care plans did not give care staff clear guidance about how to meet people's needs. Care staff relied on relatives, people and other care staff who shared verbally information between them to gain knowledge about people's needs. Staff were not always accurately completing people's contact sheets. The provider said they would take action to improve their record keeping .

People were supported to eat and drink by care staff who knew what their food preferences were. However care staff had not always informed the management team of concerns when one person was taking a poor diet. The management team consulted health and social care professionals when needed.

Care staff asked for people's consent before they gave any care. They had an awareness of the Mental Capacity Act (2005) and knew when to report any changes.

People knew who to contact if they had a problem or complaint. Concerns were taken seriously and investigated.

The provider actively sought the views of people, staff and relatives to develop the service.

The service audits to monitor and continually improve the service had not been completed effectively. The shortfalls we found in care plans and medicine records had not been identified.

We found three 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

Some aspects of the service were not safe.

People's medicines were not managed in a safe and appropriate way.

Pre-employment checks had been completed on staff prior to them starting work.

Risk assessments were in place and up to date.

People were supported by care staff who arrived on time and stayed for the agreed length of time. Action was taken following missed visits to prevent a recurrence.

Care staff were aware of the procedures to follow to report abuse.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Care staff received six monthly supervisions and annual appraisals.

People were supported by care staff who undertook the training to help support them effectively. However there was not a system to monitor all staff's effectiveness of their learning or care practice and competence.

People's rights were protected because staff understood the importance of gaining consent and involving people in their care.

People were supported to access health and social care professionals when needed.

Is the service caring?

Good

The service was caring.

People and relatives were happy with the care provided. The majority said care staff treated them with kindness and respect.

People were involved in how their care was provided on a daily basis.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People had an assessment of their needs carried out before they received care. However care plans did not contain all the information necessary to guide care staff about how to meet people's needs in a consistent and safe way.

People were aware of who to contact if they wished to make a complaint.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider was managing the service supported by an assistant manager and deputy manager. People and staff spoke positively about the management team.

Systems were in place to regularly monitor the service to ensure good quality care was being provided. Audits had been carried out but were not effective in identifying the concerns we found regarding the medicine records, care plans and effective competence and observation checks.

People, relatives and staff's views and suggestions were taken into account to improve the service.

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Detailed findings

Background to this inspection

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

This inspection took place over two days on 27 and 28 July 2016. The inspection was announced and we gave 48 hours' notice. This was because the location provides a domiciliary care service and we needed to make sure the provider and assistant manager would be available during our inspection. The inspection team consisted of one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information to ensure we identified good practice and addressed any potential areas of concern. This included previous inspection reports and other information held by the Care Quality Commission (CQC), such as statutory notifications. A notification is information about important events which the service is required to send us by law.

We sent out 30 questionnaires to people and their relatives who used the service of which 15 were returned.

During our inspection we visited three people in their own homes and also spoke with two family members. We contacted seven people and their relatives by telephone to ask them their views about the service.

We also spoke to nine members of staff; this included the provider, the assistant manager, deputy manager, care coordinator, senior care worker referred to as a supervisor at the service and four care staff.

We reviewed records about people's care and how the service was managed. These included four people's care and medicine records, four staff recruitment files, staff training records, minutes of meetings, complaints/compliments and a selection of policies and procedures relating to the management of the service.

We sought feedback from three health and social care professionals and commissioners of the service and the local safeguarding team. We received responses from one of them.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not managed in a safe and appropriate way. The senior staff at the provider's office wrote the medicine administration records (MAR) charts to go into people's homes for staff to use as guidance to administer people's medicines. A MAR is used to record prescribed medicines for a person. They should contain information about the dose the person requires the frequency, quantity and information to ensure the medicines are administered safely. However the MAR charts produced by the service only recorded the actual medicine name and no further details.

Where possible the assistant manager had worked with people and their pharmacists to have medicines put into a monitored dosage system (MDS). Where people had medicines supplied in MDS blister packs, it was recorded on their MAR that staff should administer medicines in the blister pack. Some people were prescribed medicines provided in packaging. This included topical skin creams, antibiotics and inhalers. Although the medicine names were recorded on the MAR, there were no instructions for staff on their use. This meant staff did not have the information needed to ensure they administered medicines as prescribed. One relative said, "I do have to remind them to put cream on his back and they do it."

Care staff had undertaken a DVD-based medicine training programme and had also completed a workbook. However, their competency to administer medicines safely had not been checked which is good practice.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were happy with the service. One person responded on their questionnaire, "They are very friendly. I feel safe…they always see if I have any red marks caused by pressure on my skin so I do feel safe."

Care staff were knowledgeable in how to recognise signs of potential abuse. They knew who to report concerns to, including the management team and other agencies. There was an up to date copy of the service's safeguarding policy and procedure, which included guidance from the local authority. There had been two safeguarding concerns reported to the local authority in the last year. The management team had taken appropriate action in response to these concerns. For example they had added a new check which care staff completed at each visit. This check required staff to monitor people's vulnerable areas of skin to ensure they were not sore and to report concerns to the office. The provider said they were looking to improve the monitoring of people's skin further where people were at risk of developing pressure areas.

Recruitment records confirmed all the necessary pre-employment information had been received. This included an application form, suitable references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers prevent unsuitable people from working with vulnerable people who use care and support services. Interviews were carried out during which staff were asked what actions they would take in different care scenarios. The management team said they discussed gaps in employment history with prospective staff but these were not recorded.

People said they were usually informed which care staff would be visiting as they received a weekly rota, brought to them by the care staff. One person said, "I had my list today. There are several blanks so I don't know yet but I know most of them." Another said, "It would be nice to have the same one all week, I do have different girls all the time." A relative said, "We don't get the same carers every day. On the whole we get a dozen to 16 girls who alternate." However one person said, "If the carer on my list isn't able to come I would like them to let me know. Sometimes they do but not always." Another relative said, "Sometimes mum, who is severely disabled, is introduced to new carers but sometimes they just turn up to get her showered and dressed or put her to bed. Mum has found this distressful on several occasions."

A staff member said, "I have a few consistent ones (people) but can vary at other times. Generally good except school holidays." The provider said people were contacted by the office staff regarding any changes to their care worker allocation because of unexpected sickness or changes to care staff availability. The office staff kept a log of telephone calls to demonstrate people had been informed. One relative said, "We are phoned if there are any changes. There can be a delay but we do get someone." The service used a computer based system to record the availability of staff and match people to care staff and tried to keep continuity. However the provider said during the summer holiday period there needed to be more changes due to staff availability.

The service had experienced staffing issues due to care staff leaving, planned sickness and unplanned short notice sickness. The management team had needed to prioritise visits and managed to cover the shortfalls. Care staff worked extra hours and the management team delivered hands-on care. The provider said, "We have a good core staff, some have left and then decided to come back. We only allow one full time staff member and one part time off for annual leave at any time to reduce the impact of holidays." New staff were in various stages of recruitment and the service was still actively recruiting.

People and relatives on the whole said care staff came at the scheduled time and stayed their planned time. One person said, "They are pretty good really, I haven't had much trouble. " Another said "I have good and bad. Some stay 15 minutes some stay 25 minutes but that has got better recently." The provider required that people and their relatives signed care staff's time sheets confirming they had been and stayed the correct time. The time sheet were taken to the office each week to be checked and used to calculate staff wages.

There had been some missed visits by care staff. The management team had assessed people's vulnerability and ability to contact the service should their care worker not turn up. They had put in place eight mobile phones for people assessed as vulnerable. These were kept at people's homes with their permission and care staff were required to call in when they arrived. These phones were connected to the provider's computer system and should a care worker not arrive within 30 minutes of their expected arrival time an alert would flag up on the provider's computer system to make the management team aware. The assistant manager said if they needed more mobile phones they would be purchased if required. The assistant manager had responded to one person who had a missed visit. They had put in place a mobile phone to minimise the risk of it happening again. There was no formal system to monitor that other people did not have a missed visit. The provider said they were happy that people and their relatives would contact them if there was a problem. Following the inspection the provider made us aware they were looking at implementing a new system which would be more effective and not require the use of time sheets.

Risks to people had been identified. When people started using the service an assessment was completed to assess the level of need and risk. The assessor looked at the person's internal and external environment. This included the neighbourhood, parking, security of access, floor coverings, work space and animals. They also undertook fire risk assessment and medicine risk assessment. This was reviewed annually or if people's

needs changed. The computer system used by the provider had an alert system to flag up when reviews were due. The assistant manager said they were reviewed more frequently if people's needs changed. However two people had been in hospital and had on discharge, had resumed their care package with the service. Only one of these people had had their care needs reviewed when they came out of hospital. We discussed this with the provider and following our visit they undertook a review of this person. Following the inspection the provider made us aware that their records showed the assistant manager had undertaken a visit to the second person when they were discharged from hospital .

People said care staff left their premises secure and closed doors, windows and gates behind them. Where people were unable to let care staff in themselves, a keypad entry system had been installed and was used safely. The numbers were kept secure and only given to those people who needed it.

Care staff said they had personal protection equipment (PPE) supplied which was readily available. This included gloves, aprons, hand gel and masks if required. People confirmed staff used plastic aprons and gloves when they gave care and support in their homes. All staff had undertaken infection prevention and control training. Supervisors visiting people's homes completed an observations form which included checking that staff had used the PPE provided. When the provider had concerns raised regarding poor infection control practice they had written to staff reminding them of the importance of using gloves and aprons. They had also highlighted to the supervisors to be even more vigilant when undertaking their checks.

Requires Improvement

Is the service effective?

Our findings

New care staff received induction training when they began working at First React. The provider had used the Care Certificate to support new staff without experience of working in care for their learning and development. The Care Certificate is a set of national standards that social care and health workers should demonstrate in their daily working life. The standards should be covered as part of induction training of new care workers. The assistant manager said new care staff 'shadowed' an experienced care worker until they felt comfortable to work on their own. They said the amount of shadow shifts depended on the new staff's previous experience and they usually undertook three to four shadow shifts. As part of their induction, new care staff completed an induction checklist with a senior member of staff. This included information about the provider's systems and policies. The experienced care worker would also go through a checklist of the routines of people they were supporting. Two recently employed care staff both said they had worked shadow shifts. One care worker had shadowed for three shifts and completed the Care Certificate. The other had completed one shadow shift and had then been the second care worker for people who required two staff to support them. Both said they felt they had received sufficient support to enable them to work on their own.

Once new staff had completed the provider's induction there was no system to monitor their practice or assess their competence. The first formal meeting they had was their six monthly supervision. We discussed this with the provider who said all staff came to the office at least twice a week to collect their allocation sheets and to give in their time sheets. The provider said they also asked staff during these visits if things were alright. The provider said they would look at improving the formal oversight of new staff to ensure they had continued good practice. Following the inspection the provider made us aware that they had made changes to improve staff monitoring and competency observations.

Care staff received a formal supervision every six months and an annual appraisal to support them in their roles and identify any future professional development needs. There was a system on the provider's computer system to identify when staff supervisions and appraisals were required. Staff met with their line manager for their formal supervisions and topics discussed included the provider's health and safety policy, principles of care and planning and areas of development. They also discussed any concerns or issues which had arisen. For example a medicine error or a missed visit. Care staff said they felt supported by the management team.

Checks and observations of care staff's practice in people's homes (spot checks) had been carried out. However spot checks were undertaken randomly and the majority were undertaken when a supervisor was working with another care worker. For example when the supervisor and the care staff were both working with a person who required two staff to support them. Therefore there was no system to check that all staff were undertaking their duties as required when working independently. When spot checks were carried out by the supervisors they checked the staff member's punctuality, uniform and whether they had gloves, aprons, hand gel and their identification card. They also checked whether staff treated people with dignity and the person's care plan was followed. One supervisor said, "I do spot checks to ask staff how things are going and if they (staff member) have any concerns or support required."

Care staff received training using a DVD training programme followed by completing a workbook. The mandatory training at the service included manual handling, first aid, safeguarding vulnerable adults, Mental Capacity Act 2005 (MCA), infection control, food hygiene and fire safety. The computer programme used by the provider flagged up when staff needed to complete their annual update training. The provider had approached a senior member of staff to undertake a 'train the trainer' course in manual handling. This was so they could deliver practical manual handling sessions to six new care staff that had started working at the service since their previous trainer had left. In the mean time staff who had not received manual handling practical training worked alongside care staff who were trained. The assistant manager said all care staff were undertaking pressure ulcer prevention training and were planning to start hearing aid and documentation training. Staff said they had received training but would prefer more. Comments included, "I did the manual handling training and two sessions using a hoist at a service users and a turntable" and "Not enough really. we don't have the physical side of training which would be better."

People and relatives who completed a Care Quality Commission (CQC) questionnaire were mostly happy the care staff had the skills and knowledge they required to meet their support needs. Of the people who had responded 83% agreed and 100% of relatives agreed that care staff had the skills and knowledge required to meet their and their relatives care and support needs.

However we had mixed responses from people and relatives we spoke with. Comments included, "They are very good, I have no complaints", Most are, some are better than others. Some of the girls are good at coaxing others aren't so good they have to have the right attitude. Whether it is down to training or personality on the whole ok" and "It is down to the route (initial) training that is the problem with some of them, they will cheat and cut corners."

The agency was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff demonstrated an understanding of the MCA and how it applied to their practice. 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 a person lacks mental capacity to take a particular decision, any decision made on their behalf must be in their best interests and as least restrictive as possible. Wherever possible, best interest decisions should involve people who know the person well, including family and anyone who have been given Power of Attorney by the person. Health and social care professionals should also be involved where appropriate. Where a person does not have family or a Power of Attorney, an application to the Court of Protection may be necessary to have a court appointee for the person. Although the management team were aware of the function of the Court of Protection, no applications had been made for appointees. Care staff were aware they needed to gain people's consent to care and knew to report concerns to the management team when necessary. People we visited said care staff always asked for consent before giving care and support. The provider requested that people sign a formal consent for receiving care from the service.

Care staff helped some people as part of their package of care by preparing meals and snacks. This meant that care staff ensured people had food and drink available within reach before they left. All staff had received training in food hygiene. Records were kept of what and how much people ate and drank in the daily visit records. However records of one person's dietary intake had been very poor. Staff had not alerted the management team that the person had been refusing and only having a small diet. Therefore action had not been able to be taken to inform relevant health professionals. Following the inspection the provider made us aware they had reinforced with staff the need to inform the management team of changes in people's dietary needs.

People had been supported to see health and social care professionals when they needed to. People's care records showed health and social care professionals were involved in people's individual care on an on-going and timely basis. For example, GPs, district nurses and occupational therapists. One relative said, "I have been pleased that they have called a doctor when required or updated me whenever there has been a problem." During our visit the assistant manager was in contact with a health professional to arrange the equipment to meet one person's needs.

Good

Is the service caring?

Our findings

People and relatives, with the exception of one person, who completed the Care Quality Commission (CQC) questionnaire, said they were happy with the care and support they received and felt care staff were caring and kind. Comments included, "The service from all carers are great thanks to First React. My last care agency which I left was not half as good in actually listening to me" and "I have seen the carers they are always polite."

People received information about the service provided. Each person had a service guide in their folders in their homes. This contained information about the provider's complaints procedure; office contact details and the emergency 'out of hours' contact details. One relative was not happy with the office staff. They commented, "In general the girls who work for First React are kind and thoughtful; however the people in the office are less helpful and have upset mum on several occasions." We discussed this with the management team at the office. They said they were aware of the concern and the staff member they felt was responsible no longer worked at the service. During our visit, telephone calls were answered promptly and there was a happy rapport with people on the telephone.

Most people and relatives we spoke with were also complimentary about the care staff. Comments included, "Very good, we have a good laugh. They always turn up" and "Very good. Some you like more than others." However some people had some issues about some staff for example, One relative said, "95% of the girls are excellent just a few personality clashes." One care worker said, "I am happy clients are cared for. Everything goes swimmingly, good care, carers are always on time when I have been working with them."

Each person and their relative who completed the CQC questionnaire said they were treated with respect and dignity by care staff. This was also confirmed by people and relatives we spoke with.

Relatives said they were involved with their family member's assessment when they started using the service and they felt listened to. They confirmed the care and support they needed was carried out as they wished. Staff ensured people were involved in decisions about their care and support. For example what tasks they wanted to be undertaken, what food was prepared for meals and what clothes they would like to wear.

The service had received compliment and thank you cards. These included one with the comments written ''We are very satisfied with the care your support care worker girls give to both of us. Many thanks to all."

Requires Improvement

Is the service responsive?

Our findings

People had an assessment of their care needs carried out by a member of the management team when they started using the service. Once people started using the service from First React a care plan was put in place (referred to as a routine plan at the service). Care plans are a tool used to inform and direct staff about people's health and social care needs. First Reacts care plans were not detailed and did not contain all the necessary information required to deliver care according to people's needs. For example, one person was living with diabetes. This had been recorded in the initial risk assessment for this person. Staff provided support to this person with their meals. However there was no guidance in the care plan regarding their diabetes and ensuring they had appropriate meals. This person also required assistance with their personal hygiene. The plan from the local authority identified that they may refuse to have support in the morning and that the care staff should try again in the evening. This was not recorded in the care plan. Therefore if the person refused support with their hygiene needs in the morning they would not be offered the support again until the following morning.

A second person was at risk of choking and required care staff to be present while they ate their meals. However this guidance had not been included in the care plan which meant care staff might not be aware they had to do this. However the person said care staff did stay within their proximity while they were eating. The provider told us after the inspection that the speech and language therapists guidance was available for staff on the fridge door in the kitchen.

A third person required the use of a hoist and a slide sheet to be repositioned. The care plan did not guide staff regarding the use of the hoist and about how to reposition them. There was also no guidance regarding the disposal of continence pads and emptying of catheter bags.

This information was important as care staff were not always familiar with the people and their needs that they were scheduled to visit. Therefore, they needed to rely on the information in the care plans, especially if people were not able to tell them what care they needed. In some cases staff relied on the person or relative to tell them. One person said, "I can tell them what to do, what I want." A relative said, "You have to tell them details over and over again."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the majority of people we spoke with felt their care and support needs were met by care staff. This was due to care staff knowing people's needs and information being shared verbally between people' relatives and staff.

Staff complete a contact sheet for every visit. The contact sheet was populated with instructions for the care staff and has a space for them to record what they had done during their visit. One of the instructions which staff ticked to indicate they had done was whether they had read the care plan, continuous risk assessment and routine plan. In one person's care record, staff had ticked the contact sheet to say they had read the

care plan. However there was no care plan in the person's file although there was a care plan at the office on the provider's computer. We discussed this with the provider who said they would take a care plan to the person's house that day. Therefore care staff were not always accurately completing people's contact sheets.

We discussed the lack of information in care plans and staff not completing contact sheets accurately with the provider. They acknowledged care plans did not provide sufficient detail to support staff to deliver the care required. They said they would review people's care plans to ensure they contained sufficient information to support staff and discuss with staff the importance of accurate record keeping.

After the inspection a relative said they had been visited that day by the provider. They had been shown new care plans put in place by the provider following our inspection. They were asked if they contained the correct information and said they were happy they did.

Care folders contained a list of personal information and identified relevant people involved in people's care, such as the GP and community nurse so care staff knew who to contact if necessary.

People and their relatives said they felt comfortable to raise any concerns. Comments included, "If I had a grumble I would raise it. If I had one", "No need to complain", "If I had a complaint. I would get on the phone" and "I will speak up if not happy I will raise it with them, 90% of the time they take it on board." One person gave an example where they had raised a concern. This was regarding how a member of staff had spoken to them. The person said they did not want the member of staff to visit again. They said, "I told them and they stopped her coming. No trouble since." In each person's folder in their homes there was an information sheet advising people and their relatives how they could raise a concern. However only 67% of responses from people who completed the CQC questionnaire said they knew how to make a complaint. When these people were also asked whether 'the staff at the care agency respond well to any complaints or concerns I raise'. The responses were 67% agreed, 17% did not know and 9% disagreed.

The provider said they dealt with a lot of issues under concerns rather than complaints. These included, missed visits, late visits, safeguarding concerns and medicine errors. Where they had received a concern regarding a missed visit the provider had taken action and put in place a mobile phone for staff to contact the office when they arrived. They had received two complaints which they had responded to the complainant in line with their complaints policy. One complaint was regarding care staff not always disposing of continence pads in the correct way and the second regarding care staff not staying the required time for a visit. The provider had taken action regarding both of these complaints. They had met with relevant care staff and sent a text to all staff reminding them to place pads in the clinical waste bins provided.

Requires Improvement

Is the service well-led?

Our findings

Effective governance systems, such as regular audits, should enable continuous improvement of the service. However, these had not been undertaken effectively. Audits had not identified that care plans and medicine records did not contain enough detail to guide staff to deliver safe care. Spot checks and observations were being carried out randomly to assess care staff practice and accurate care records. However there was no system to ensure all staff had their practice checked and all care records were reviewed. There was no system to ensure care staff were competent to administer people's medicines.

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

Following the inspection the provider made us aware that they had taken action to address the concerns found. This included updating medicine administration records and improved staff monitoring, assessment and observations .

The service had a condition on its registration with the Care Quality Commission (CQC) that they required a registered manager. The last registered manager deregistered with CQC in September 2015. The provider had made an application to CQC to have the condition removed. Following the inspection the provider made us aware that they had withdrawn their application to remove the condition of having a registered manager in post. They confirmed an application was being submitted for a new registered manager. The provider was managing the service herself supported by an assistant manager and the deputy manager. The assistant manager was in day to day control of the service and had the support of the deputy manager on a part time basis. The provider was available on a Wednesday and Friday and could be called upon for advice and guidance whenever needed.

The service had recently appointed a new care coordinator. They were, as part of their induction, meeting all of the people using the service to get to know them and their support needs. Their planned role was to manage visits to people, phone calls to health services, support the assistant manager and undertake spot checks on staff to ensure they were carrying out their roles correctly. The care coordinator said, "Staff are listening, I am supporting staff trying to get a happy medium. There are some changes I would like to implement which I have been able to suggest." The care coordinator worked alongside two supervisors, who undertook staff checks, undertook on- call duties, care delivery and supervisions.

People who used the service and care staff were supported by an on-call rota. This provided advice, support and guidance outside of office hours when necessary. Care staff said their calls were responded to quickly. Ninety two percent of people and 100% of relatives who responded to the Care Quality Commission questionnaire knew who to contact in the care agency if they needed to.

Staff were positive about the management team. Comments included, "(The assistant manager) is fitting in well, the boundaries have been tightened", "No problem with them at all, they treat me very well", "(Assistant manager and provider) are very supportive" and "I love it and all the office staff. I would phone

the office or who is on call; whatever has gone wrong it is sorted in no time."

Audits were carried out to assess that staff had completed care records accurately. The provider undertook checks selected at random of people's medicine administration records and contact sheets each month.

A new Medicine Administration Record (MAR) was put in place each month for each person in their home. At the end of each month the MAR was returned to the office. The provider undertook an audit of a random selection of the MAR to monitor if they had been filled in correctly. When they identified concerns a letter was sent out and/or a meeting held with the relevant staff members. For example, a missing signature, name, date, or staff not using black ink, which is the provider's preference.

There had been three medicine errors in February and March 2016, where staff had given the wrong medicines to people at the wrong times. The provider had taken appropriate action and contacted health professionals for advice which had been followed.

The provider wrote in their provider information return (PIR), "As a dynamic and responsible care provider we are committed to continuously challenge and review its services in order to ensure that they are truly responsive to the needs of our clients and are delivered in the most appropriate, accessible and efficient way possible. We found the management team were actively looking to improve the service provided and were responsive following discussions.

The management team were working on promoting an open culture at the service. Every Monday they held an open forum meeting at the office. Staff, people and relatives were able to call in for a chat about any issues worrying them. The provider produced a newsletter every six months which was given to all of the people using the service and staff. The Spring 2016 newsletter included information about the service what was happening and important local contact telephone numbers. For example, advising people about the open forum meetings, about the new office staff, if they needed assistance to get out and details of local organisations.

People's views and suggestions were sought to improve the service. The provider sent out a survey every six months to people, relatives and staff. The last survey was completed in March 2016. The provider had collated the results and a letter sent to people with the responses. However the letter did not identify any changes which had been made as a result of the people's responses. On the whole the responses were complimentary of the service delivered and the skills of the care staff.

The provider ensured staff were kept informed and actively sought their views. A staff meeting was held every six months. Although these were not always well attended staff were able to read the minutes of the meetings to be kept informed. Supervisors meetings were held to discuss issues and changes. One supervisor said, "They are useful, we can bounce off each other. We have them every couple of months or if something needs dealing with."

There were systems in place for the provider to keep staff informed about changes or concerns. One of these systems was to send a group telephone text, which all staff had to respond to confirm they had read it. At other times a memo was produced which staff had to sign they have read and understood. Staff said they had good communication systems at the service and they were kept up to date by telephone texts and memo's to ensure they knew about any changes with a person's care needs. For example, if a person started on a course of antibiotics for an infection, a text message would be sent to all relevant staff advising them of the change. One care worker said, "We have constant communication with the office, we are kept informed." Another said "We have meetings and memos about what's changed and what's happened."

There were accident and incident reporting systems in place at the service. The provider reviewed incidents to look if there were any patterns in regards to care staff or themes. The provider was meeting their legal obligations such as submitting statutory notifications to the CQC. A notification is information about important events, which the provider is required to tell us about by law. They notified the CQC as required and provided additional information promptly when requested and working in line with their registration.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not taken proper steps to ensure the safe care and treatment of service users. They had not designing a plan of care to meet their needs and preferences. 9 (1) (a)(b)(c) (3) (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken proper steps to provide care and treatment in a safe way for service users. They had not ensured the proper and safe management of medicines 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed and monitored the service effectively. 17 (1) (2)(a)