Alandra Care Limited

# Alandra Care Limited

## Inspection report

Arun House
River Way
Uckfield
East Sussex
TN22 1SL

Tel: 01825767857
Website: www.alandracare.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 inspected Alandra Care Limited on 2nd October 2017. The inspection was announced: We gave 48 hours' notice of the inspection to allow enough time for the provider to arrange for us to visit people in their own homes on the day of the inspection.

Alandra Care Limited is a domiciliary care agency that provides personal care support to people in their own homes. The majority of people who receive support are older people aged 65 or over. People using the service have varying support needs, including physical disabilities, sensory impairments and dementia. People require varying levels of support, for example; some people may only require support once or twice a week, whilst others will require more than one call a day and support from two carers. At the time of our inspection the service was supporting 48 people.

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

Alandra Care Limited was last inspected in May 2015. At that inspection it was rated good overall, and good in all domains. At this inspection the provider had not ensured they had maintained this and improvements are needed in a number of areas:

People's support with medicines did not always correspond with the assessment of their needs and medicine records maintained by the service were not always up to date or accurate. Identification of risk and actions agreed to ensure the support provided was safe was missing for some people who had support with their medicines.

The service had recruitment and deployment issues with staff. Despite taking steps to address these issues the service had frequently not been able to ensure enough staff to cover shifts at weekends and some people were receiving consistently late care calls as a result.

Identification of risks to people in other areas of their support lacked formal guidance for staff about how to manage these risks safely. Peoples' care plans sometimes lacked detail about people's preferences and the support they needed.

Since the last inspection took place on the 8th and 19th May 2015, the provider had not always submitted notifications about important events at the service to the Care Quality Commission, as required by law.

The registered manager employed a range of systems to monitor and identify issues and areas for improvement at the service. However, issues were not always formally recorded and the provider had not always taken effective action in response to findings from the quality assurance systems or from people

using the service and staff feedback.

Staff completed a comprehensive induction in which they obtained a QCF Level 2 Diploma in Health and Social Care, as well as receiving training in a range of relevant subjects. The registered manager was proactive about providing more specialised training for staff if the need arose. However, some staff training was not up to date and this meant staff did not always have the latest knowledge and skills when carrying out their roles. We have made a recommendation about updating staff training and reviewing this at appropriate intervals.

The service had an ethos of person centred care and involved people in the planning and delivery of their care. The service regularly reviewed people's care and responded well to meeting any changes with people's needs. However, the level of detail in people's care plans did not always reflect their needs and preferences. We have made a recommendation about updating people's care plans.

People had experienced positive outcomes with their health after being supported to access healthcare services. There was not always sufficient information in people's care plans for staff to accurately support people with their health needs. We have made a recommendation about sourcing and providing this information.
People felt empowered to speak up if they were not happy at any time. The registered manager and staff listened to and took action when receiving complaints and concerns. People and their relatives told us that they felt safe and care staff and management responded well to accidents and incidents, including safeguarding concerns.

The service was working to the principles of the Mental Capacity Act, staff and the registered manager clearly understood how to gain people's consent to their care and documented this accordingly. Staff received regular supervisions and on-site spot checks to help support them to achieve best practice. People received support with their meals in a manner that suited their needs, choices and preferences.

People received care from staff that knew them well. People and their relatives spoke highly of the caring nature of staff. The staff and registered manager placed a lot of value in developing positive relationships with people. People were encouraged to express their views about the provision of their care. Staff respected people's privacy, confidentiality, dignity and knew how to meet their needs.

People and staff were involved in identifying quality issues. The service sent surveys to people using the service and compiled action plans to improve the service based on their responses. Staff had regular team meetings and supervisions where they could discuss individual, team and service issues with management and agree appropriate actions to take. There was a positive, open culture at the service and staff felt well managed and supported.

We found a number of breaches in 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 this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Safe and proper use and management of medicines was not consistent.

There were not always enough staff to support people at weekends and people frequently received late calls.

Identification of risks to people lacked formal guidance about how to manage these risks safely.

Care staff and management responded well to safeguarding and other accident and incidents.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff had not received regular training to ensure they were up to date with best practice and knowledge.

Information about people's health needs required more detail in people's care plans and risk assessments.

Staff received a through induction and had regular supervisions.

People consented to their care and the service operated within the principles of the Mental Capacity Act.

People received support with their meals.

### Is the service caring?

**Good**

The service was caring.

People using the service spoke highly of the caring approach from staff.

There were positive and caring relationships between staff and people.

People were involved in their care and encouraged to express their views about their support.

People's privacy and dignity was respected.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care plans did not always contain sufficient detail about their needs, wants and preferences.

People received personalised care and had been involved in identifying how they wanted to be supported.

The service listened to and acted on concerns and complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

The provider had not always submitted notifications about events at the service to the Care Quality Commission, as required by law.

Quality Assurance systems were in place but had not always formally identified issues. The provider had not always taken effective action in response to areas for improvement that had been identified.

There was a positive, open and supportive culture at the service.

People and staff were consulted about identifying improvements to the service.

# Alandra Care Limited

**Detailed findings**

## Background to this inspection

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

This inspection took place on 2nd October 2017 and was announced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. For this inspection, the expert's area of expertise included elder people using regulated services and dementia care.

Before our inspection, we asked the provider to complete 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 the PIR and other information we held about the home, including previous inspection reports. We used feedback about the service from questionnaires we sent to people, relatives of people using the service, staff and community professionals. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with two of the people who used the service and spoke with eight by telephone. We also spoke with two relatives, three support workers, the registered manager and the company director.We 'pathway tracked' six of the people using the service. This is when we looked at people's care documentation in depth, and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

After the inspection, we asked the provider to send us copies of two people's care plans for us to look at, which they sent to us the following day.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe. One person said, "Yes (I feel) absolutely safe at all times". A person's relative told us "Yes my relative has no issues of safety or any harm". We spoke to staff that were aware of how to record and report any concerns about people's safety. However, despite this feedback we found the service required improvement to ensure consistently safe practice.

Assessment of people's support needs with medicines was not always consistent with the practice of staff supporting them. We visited one person whose care plan assessed the support they required with medicines as 'None- The person self-administers their medication'. There was no detail in the medication care plan assessing the risks associated with this person self-managing their medication. We observed staff verbally prompting the person to take their medication. We spoke to staff about this. Staff confirmed they regularly verbally prompted and sometimes physically gave medicine to the person. Staff explained this level of support was needed because, due to their support needs, the person might forget to take or could sometimes have difficulty getting the medicine out of the packaging themselves. The registered manager had recently completed a medication audit form for the person but had not confirmed these risks or re-assessed the person's level of support needs. The lack of clarity over the assessment, guidelines and practice in this instance presented an increased, avoidable risk the person might not receive their medicines safely.

Another person's medication assessment indicated they were able to self-administer insulin, which was essential to successfully managing their diabetes safely. There was no recorded assessment of the risk to the person self-administering this medicine. We observed staff physically supporting the person to access their insulin before they self-administered the medicine and supporting them to record their blood sugar levels. There was no specific guidance for staff around supporting this person with their diabetes. The same person was assessed as needing 'General Support/Verbal Prompting/Reminding' with other medicines they were prescribed. The care plan included directions for staff to physically administer some medicines and give them to the person. We observed staff physically administering medication for the person. The person's care plan documented that at certain times staff administer medicines and leave for the person to take later. There was no corresponding risk assessment in place that confirmed leaving the medication was a safe thing to do. We observed staff offering to administer the person's As Required (PRN) medicine. There was no specific plan for administration of this PRN medicine recorded in the person's Care Plan or kept with the medication administration records (MAR). In all of these examples, there was a risk lack of clear guidance regarding people safely receiving their medicines in a manner that suited them could place people at increased risk of harm.

We viewed several MAR for people in the archives at the registered office. One person's MAR chart contained consistent unexplained gaps where staff had not signed to indicate the person had been supported to receive their medication. We asked the registered manager about this and they explained the person did not receive support on the days where there were gaps. However, there were no codes entered into the MAR to confirm the details of the non-administration. For other gaps on the MAR, medicine had been discontinued

but was not removed from the MAR. Although staff received medication training, when we reviewed staff training records we saw three staff's annual safe administration of medication training was out of date by 17 months or more. When we spoke to staff they did not always seem confident about their responsibilities when supporting people with medication. One staff member told us "if I was unsure about medication then I would miss a dose, rather than give something that I'm not sure about. I don't think that there is anyone that would come to any harm". When presented with the concern this was dangerous practice, the staff member clarified "there should be someone in the office or at the GP's that I can get hold off to discuss the medicines, but if I couldn't then I wouldn't give it". We sampled two medication audits the registered manager had recently completed and saw common themes included staff forgetting to sign MAR charts once they had given people medicines and further instances of incorrect coding on MAR charts. We saw a staff memo from the registered manager addressing these issues with staff as improper practice and prompting staff to read medication policies. However, these actions had not ensured consistency in keeping medicine records up to date or appropriate recording taking place. This presented an increased risk that people may not receive their medication as intended.

The failure to ensure all reasonably practicable measures to mitigate the risks regarding safe and proper use and management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of suitable staff at the service to keep people safe and to meet their needs. We received consistent feedback from people about calls being late, particularly at the weekends, and this was upsetting and stressful for them. One person told us "I am not really happy with the timings- I expect them to come in the morning between 9-10 am – they come at 11.45 am". Another person said, "I feel the rotas are all over the place- the company should get the care workers to come on time at least. I really do not need this stress." Relatives also raised concerns over late calls, one person told us "I am afraid timing is up and down- they were expected at 9.30 am – they came between 11.00-12.00pm." Another relative said, "The timings need to be sorted out- it seems that they have less staff or there is some shortage as they are always late".

Staff and the registered manager confirmed there was a problem with staff shortages and staff being available to work at weekends, which is why the calls were late. One staff member told us "There is no staffing at weekends". Another staff member said, "people are not getting the calls when they want". We discussed how the service was meeting people's needs given these issues. Staff and the registered manager told us they came in to work extra shifts at the weekends to cover the care calls. Visits to people who had medication or manual handling support at specific times took priority over other more able people. The service informed people if their support calls were going to be late and people confirmed staff would "eventually turn up" so, although late, calls always took place. However, people with less urgent support needs were consistently not getting support when they wanted it at times they had agreed and this was causing them a degree of stress and emotional upset.

Staff including the registered manager, told us of the negative impact of having to come in on their days off to cover shifts at the weekend due to increased actual workload and the psychological pressure of feeling they could not say 'no' as they knew people would not get any support if they did not work. One person told us "Weekends are tricky, we always get the calls covered but staff get tired". From reviewing conversations with staff and people using the service and records of memos to staff and team meeting minutes we saw staffing issues had been on-going for over three months. There were plans to review deployment of current staff's weekend working patterns on the service rota. Despite taking recent steps to address this, the failure to deploy sufficient numbers of staff over a protracted period of time is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the identification, assessment and management of risk in other areas of people's support provided by the service. When we sampled people's risk assessments, although identified, there was a lack of detail and guidance for staff regarding how to mitigate risks. For example, people being identified as frequently experiencing ulcers as a result of their health conditions did not have an associated skin integrity risk assessment, capturing all necessary actions staff were to take to support this person safely. Similarly, a person assessed as being at risk of falls and requiring support with transfers had no guidance in a risk assessment or care plan regarding how staff should support them to transfer safely. We discussed the potential of avoidable harm for people not having robust enough risk assessments in place presented. The registered manager advised us staff knew all of the people very well and worked with families, other agencies such as healthcare services and people they were supporting to share information necessary to manage risks to people informally. We observed this to be the case from the support provided to people we visited and people told us that they had consistency with their support, including competent risk management where this was applicable. We saw the registered manager was working on a comprehensive review of people's care plans and risk assessments to address the gap between staff practice and the current detail and guidance in the plans. Despite these actions being underway, the failure to have in place robust risk assessments and formal guidance about how to manage risks to people safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed accident and incident forms and recorded notes into daily logs to keep a record of any concerns that they might have about people's safety. In addition, people could phone the office or out of hours on-call service straight away at any time. The registered manager uploaded these notes, including accident and incident forms onto a centralised system called a people planner, which allowed them easily accessible data to monitor and take action to protect people from further harm if necessary. We saw one person assessed as being at risk of falls. Staff had recorded each fall the person had on an accident and incident form as per company policy. The registered manager uploaded this information onto the people planner, analysed the content and them made a referral to a physiotherapist who provided guidelines to help staff support the person to safely manage their falls risk. We saw other examples where the registered manager had raised concerns with the local authority safeguarding team in response to reviewing staff reports and accident and incident data about a person whose behaviour had begun to raise concerns. This had resulted in a thorough investigation and multi-agency review and a revised care package had subsequently been put into place to keep the person safe.

Staff that we spoke to had a good understanding of their responsibility to keep people safe. One staff member told us if they had raised concerns internally about people's welfare and no action was being taken by their manager, they would contact the local authority social work team saying "I would go to social services direct" to make sure people were kept safe. Another staff member said they were vigilant in taking action if noticing a deterioration or change in a person's normal behaviour as this could mean they were not safe and needed help.

Safe recruitment practice took place. We checked staff files and potential staff had completed an application form, submitted two satisfactory references, a full employment history and undertook a comprehensive check from the Disclosure and Barring Service (DBS) to confirm their suitability for their role. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting.

Requires Improvement

# Is the service effective?

## Our findings

ll staff received an induction and on-going training in subjects relevant to their role, such as moving and handling, first aid, safeguarding, health and safety, diversity and equality, medication, person centred care, dementia awareness and challenging behaviour. All staff were supported to obtain a Qualifications and Credit Framework (QCF) Level 2 Diploma in Health and Social Care as a standard requirement when employed by the company. The registered manager took steps to provide extra training for staff where it was necessary. For example, following a change in a person's support needs, the registered manager arranged specific mental health training for staff so they could understand and meet the person's needs better. Staff confirmed this, telling us "if there's something that you need (specifically with training) we can tell the manager and they will act on it". People told us "Yes they are trained – things are done properly." Another person said, "I am amazed at the knowledge the care workers have – they always advise where I do not understand." A relative told us "they (staff) certainly do know what they are doing- everything is done correctly".

Not all staff had up to date training in line with the timeframes stipulated by the company policy, in several cases for more than one subject and by more than a year. The inconsistencies regarding staff practice when supporting people with medicines is an example of how not having up to date training can impact on people not getting the support they need. We discussed this with the provider and the registered manager as, although it was not clear people were not having their needs met in other areas of their support as a direct result of not having up to date training, there was an increased risk of poor practice in this respect. We asked why staff training was not up to date. The majority of training provided were online E-Learning courses, completed in the staff member's own unpaid time. Although the registered manager prompted staff, they often failed to complete courses on time. One person told us "I am behind with the training. I have other jobs and I don't have time to do this when I get home". The registered manager and other staff acknowledged that relying on people to complete training unpaid and in their own time was problematic. The registered manager had alerted the provider to this risk and the barriers staff were encountering with the current training arrangements. The provider acknowledged the barriers and the need to improve. The provider was considering how to better support staff to keep up to date with training and had recently re-introduced on-site training for staff to help address the issue. We recommend that the provider takes immediate action to renew all existing out of date staff training and ensure robust arrangements are in place to renew all staff training at appropriate intervals moving forward.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found that it was.

Staff had received training in MCA and could demonstrate how they put the principles into practice. One

staff member told us "(people) might have capacity to do certain things, but not others. Some people can decide what to do for an activity or what to wear, but not sort their finances out". If a person did not have capacity to make a decision then the service would follow a best interest process to agree the right actions to take. People's care plans contained a clear assessment of their capacity to make decisions in line with the MCA legislation. People using the service consented to their care. One person told us "staff help me to do what I want". Care records for people showed a signed informed consent agreement to their care was in place and reviewed regularly. Where people lacked the capacity to consent to their care, an appropriate person or power of attorney had signed their consent agreement on behalf of the person.

Staff received regular supervisions and appraisals, told us they felt supported with these processes and we saw records these were taking place. The registered manager had recently introduced a policy of unannounced spot checks of staff practice in people's homes to ensure delivery of care was of the expected standard. We saw records of these checks taking place and the records included recommendations to help staff improve practice or recognise good delivery of care.

People had support with eating and drinking in an inclusive manner taking into account personal preference and choice. One person said, "They always prepare the food –just like I want it." Staff told us "We always ask the client what they would like when doing their shopping". Another staff member said "people can make their own choices and we might support them with a prompt reminding them about the importance of eating a varied and healthy diet" adding as an example they always did this if concerned people were choosing to eat "a lot of ready meals". Care plans contained guidance from Speech and Language Therapist teams advising on risk management measures when supporting people with eating and drinking who had been identified at risk of choking.

People told us staff knew their routine health needs and supported them accordingly. One person told us "they look after me, if I need help with the GP for my flu injection, they take me". Staff told us if they were concerned about people's health, they would act to resolve the issue immediately and "involve the person in seeking further help". People had experienced positive outcomes with their health after preventative action had been taken by the service after staff had raised concerns. The registered manager had recently taken action to address a change in a person's health needs following staff concerns, working with the local authority safeguarding team to arrange an emergency referral to the relevant health service. However, the lack of detailed guidance at the service regarding how to manage risks to people, including those which are health related, increases the likelihood that people may not accurately supported with their health needs. We recommend that whilst the service is undertaking the current review of people's care plans and risk assessments they seek robust advice and guidance from a reputable source regarding any health related support needs and include this in people's finished documents.

Good

# Is the service caring?

## Our findings

The service worked hard to actively maintain and develop positive relationships with people. One person told us "staff know me". Staff told us "you need to take time to sit with people and talk to them, everyone is completely different and you need to know them as a person". We observed staff had a positive rapport with people. At one house we visited, a staff member had replaced the person's favourite fruit when it had run out, even though they did not support the person with their shopping, as they knew how much the person liked this fruit. Another person told us a staff member had come in on their day off to build their wardrobe, although they usually only received personal care support, as the staff member knew it was important for the person this was done as soon as possible.

People told us they received kind and compassionate support. One person commented "Excellent people...always pleasant to me. I am very glad I have the care workers…I am in fact amazed they come and look after me…I am very fortunate". Another person said, "They are brilliant…you can ask them to help you anytime, they never refuse, and they are polite, kind and lovely." A relative told us "The care workers, they are good, they make my relative very happy". A staff member told us "I care for someone as I would wish to be cared for. You are in their home, you have to respect that and you have to respect them". Another staff member echoed this sentiment saying, "you treat people like you would treat your mum or dad. You respect them".

People felt listened to and that their views mattered. One person said staff were "extremely good and will listen to what we have to say". We observed staff communicate with a person in a manner appropriate to their support needs, patiently allowing them the time they required to express themselves. Staff told us they aimed to support people to be as independent as possible, so it was important the person had the support they needed to be able to say what they wanted. The person explained this approach was beneficial for them because "I know what I want to say, staff will wait for me and then I can do it".

Staff talked to us about the importance of maintaining people's confidentiality saying "I wouldn't discuss anyone outside of work" and that it was important to "remember not to talk about other people" when in someone's home. Staff gave examples where they had made complaints about compromises to people's confidentiality by colleagues and the service had taken action to address this.

The service was committed to respecting people's privacy and dignity, as outlined in their statement of purpose which pledged to "Recognise the individual uniqueness of Service Users, staff and visitors, and treat them with dignity and respect at all times" and to "respect individual requirement for privacy at all times..". There was an Equality and Diversity Policy in place. Staff were required to read this policy to support them to understand the importance of respecting people's individual privacy and dignity from a human rights perspective.

People told us they felt supported in a way that upheld their dignity. One person told us "I have had support with personal care and staff did so without making me feel uncomfortable which is very important". Staff confirmed that they understood the importance of respecting people's privacy and dignity saying they

"always talk to people and ask them if they mind (about the support being given), give them confidence, support them to do as much as possible themselves, keep it light and make people feel comfortable"

Requires Improvement

# Is the service responsive?

## Our findings

People were involved in the planning of their care. One person told us, "The manager came here and to the hospital to assess me…I can say what I want to do". People's support was regularly reviewed by staff and the registered manager who, people told us, would "come out and visit to get to know us" as part of this process. People felt they had choice and control over their care, saying the assessments and reviews they had were "Totally brilliant, they listen, they get things done for me and they communicate all the time with me". The registered manager explained they actively wanted to know "what the person wants from us" and they had a "focus on a person centred approach" when assessing, planning, delivering and reviewing people's care. For example, accommodating preferences for male or female care staff or providing the same staff for continuity of care. A relative told us, "They do listen. We requested only female care workers, they, to date only send female workers."

Staff understood and were committed to delivering person centred care. A staff member told us they approached supporting people with the perspective "everyone is completely different, you need to know them as people" and it was important to spend time "to just sit with people before you go out (and leave the call)". People told us that they valued this approach and they felt their care was truly personalised as a result, "not just task based". We sampled people's care plans and found the level of detail recorded reflecting how people would like to receive their support did not reflect the knowledge or practice of staff we spoke to and observed. The registered manager was developing current care plans to include more detail about people's history and their personal likes and dislikes. The registered manager explained capturing this detail more accurately would support better person centred working, especially for new staff, because; "everyone has their own way of having their own care for them as a person". We saw work on these plans was in progress and the impact of people receiving inconsistent care as a result of missing detail from care plans was mitigated by current staff's knowledge of people's needs and preferences. Although the service was taking action, there remains a risk that staff may not be kept up to date with how to support people with their needs as they would choose. We recommend that the service seek to ensure that these plans are updated without any further delay.

The service responded well to ensuring they were always providing the right support to meet people's needs. If a re-assessment was required due a change in someone's needs, staff told us they would raise this with their manager to ensure "any change was necessary, the person was happy with the change and if their family was happy with the change". We saw examples of people's needs having recently been re-assessed and their care plans reviewed with their relatives following staff feedback to the registered manager. Staff confirmed this process was effective, "care plans are kept up to date, information about changes or reviews to people's needs is shared with us by the manager". We visited one person who had recently regained levels of independence with certain tasks. The person's records reflected regular reviews had taken place by the registered manager acknowledging their increased autonomy and their care plans had been updated to reflect this. We observed the person valued the fact they were more independent and that staff were respecting this change.

People knew how to raise complaints, felt comfortable to do so and were confident complaints would be acted on. One person told us, "if I have any concerns I can pick up the phone and speak to the manager and they will act on it". The same person told us they had made a complaint to the manager, "there was a very prompt response" and they were happy with the outcome. A staff member told us they took time to explore any complaints people might have saying, "we will always listen to people if they are not happy and let them know that this will be shared with the office" and that when this had happened the "manager has always acted on any complaints". The service issued a 'Service Users Handbook' to all people using their service. The handbook encouraged people to make a complaint, stating "complaints are a valuable indicator of the quality of the service and an opportunity to improve that quality". The handbook asked people to register any complaint, no matter how minor for this reason. The handbook contained a section informing people of how to make a complaint. The service recorded all complaints on a complaints form and responded within 24 hours of the initial complaint. If required for a more serious complaint, a formal written response was returned within 28 days. We saw an example of a formal response to a complaint by the registered manager, in line with the company policy. The service encouraged learning and improvement from complaints. A staff member told us "the manager talks to us if someone makes a complaint and we review this in our supervisions". We saw discussions around staff practice following complaints recorded in staff supervision notes.

Requires Improvement

# Is the service well-led?

## Our findings

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. Before our inspection, there had been no submission of notifications from the provider over the last 18 months. We discussed this with the registered manager who told us there had been several safeguarding events at the service that met the criteria for submitting a notification over the last 18 months. Although the registered manager had alerted the local authority safeguarding teams on all occasions about these events, they had not notified the CQC as a statutory requirement.

The failure to submit statutory notifications as required is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the registered office but not on their website. We discussed this with the provider and they took immediate action to rectify this. We received evidence following the inspection confirming the website now displays the rating as required.

The registered manager had recently introduced quality assurance systems at the service. These included matrices tracking staff training requirements and people's care plan review dates, as well as on-site spot checks, staff supervision objectives, medication audits and reviewing of centralised copies of staff notes regarding people's care. These systems were not always effective in identifying risks to people and areas of practice to improve. In some cases risks and areas of practice to improve had been identified by the registered manager but had not been formally recorded. Actions taken in response to issues identified by the registered manager did not always successfully rectify these issues. For example, the training matrix identified staff training was out of date and the registered manager had sent memos reminding people to complete the courses, but training was still out of date for an extended period of time for some staff. Similarly, medication audits had not formally acknowledged issues such as incorrectly completed MAR sheets or discontinued medication and the registered manager had not taken action that had resolved the issues.

By not maintaining quality assurance systems and evaluating and improving practice as necessary in respect of processing this information, the provider had not fulfilled their responsibilities regarding overall management of the regulated activity. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was actively seeking the views of people using service to include them in the process of identifying and implementing improvements. The registered manager had recently sent surveys to people, carried out an audit and created an action plan to improve practice based on the survey responses. We saw

several of the actions from this survey were completed and work was in progress on others. People told us "I received a survey and we have had feedback about what has happened". The registered manager involved staff in this process, making sure they agreed the actions on the plan with them. Staff supervisions and meetings took place regularly and the registered manager sent out regular memos, texts and newsletters to staff. We saw examples of newsletters and team meeting minutes that showed discussion regarding developments of actions in the plan and updates to staff about other service information relevant to their roles and responsibilities. Staff told us this approach was effective, saying "we know what we can and can't do".

Staff told us they felt supported by management. One staff member told us "the manager communicates well" and that "we always get a response from the office (if we contact them with an issue)". Staff felt they could talk to the registered manager about any issues, saying, "issues are always acted on by the manager". The registered manager was committed to providing a visible management presence and felt it was important to spend time getting to know people using the service in their own homes and to support staff outside of the office. Staff responded well to this approach and told us the registered manager "gets out and meets the clients…you can tell it is more than just a desk job for them".

There was a positive team culture at the service. A staff member told us "staff work together on calls and we work together as a team". Another staff member told us they did not often work with other staff due to the nature of their shifts but added; "although I don't see lots of other staff we all get on". We discussed the vision and values of the service and staff told us that everyone who worked at the service, from the top down was committed to "caring for people in a positive way". People who used the service agreed with this saying "I can swear by them- I was recommended them- I have been pleased with the company, caring, and polite people".

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Failure to submit statutory notifications as required is a breach of Regulation 18 (2) (e) (f). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Failure to ensure all reasonably practicable measures to mitigate the risks regarding safe and proper use and management of medicines 12 (2) (a) (b) (g)<br><br>Failure to complete risk assessments and plans for managing risks to people 12 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Failure to maintain quality assurance systems and evaluate and improve practice as necessary in respect of processing this information. 17 (1) (2) (a) (b) (f). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Failure to ensure sufficient deployment of staff to meet requirements of people using the service. 18 (1). |