Tipton Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 04 & 05 April 2018 and was an unannounced inspection.

At the last inspection in December 2016 the provider was found to be requiring improvement in each of the five key areas we looked at; safe, effective, caring, responsive and well-led. The provider was also in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. The provider's quality assurance practices had not always identified or addressed shortfalls in the service in a timely manner.

We inspected the service again in March 2017. This was a focused inspection to check that the provider was meeting legal requirements. We found that the provider had taken some action and made the required improvements to ensure they were meeting Regulation 17.

At this inspection we found the provider continued to operate ineffective systems to audit, monitor and improve the quality of care and support people received. The provider's systems to assess and monitor the quality of the service were not effective in identifying issues requiring improvement. There were a number of shortfalls such as poor information governance systems, risk oversight, call times and medicine arrangements. The manager was taking action and had made some improvements. However improvements identified in March 2017 had not been made. This meant that this inspection was the second consecutive inspection whereby improvements were required to the governance of the service and therefore the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what action we have taken at the end of our report.

Tipton Home Care Limited is a domiciliary care agency. It provides personal care to younger and older adults living in their own homes who may have a learning disability, physical disability, sensory disability or dementia. On the day of the inspection 350 people were receiving support; this included people who were being supported with a short enablement program following discharge from hospital.

Tipton Home Care Limited is required to and had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present for this inspection. A new manager had been in post for six weeks and told us following a successful probation period they were intending to apply to be the registered manager.

Whilst people told us they felt safe we found they were not always receiving the support they needed or at the times they needed it. The impact of late or missed care calls meant that they did not always get the help they needed to maintain their safety and well-being within their own homes. Staff received training in safeguarding people and knew where people were at risk of harm and knew how to keep them safe.

However incidents were not always recognised as potential safeguarding concerns to ensure they were referred on to the appropriate agencies at the right time. Identifying risks to people's safety and well-being was inconsistent; assessments of the risks associated with people's specific conditions lacked guidance for staff. The arrangements for supporting people with their medicines was not clear so that staff could support people safely.

There had been a high turnover of staff and some staff required training to meet people's needs effectively. Some improvements had been made to ensure staff had the support they needed to carry out their care roles. People were cared for in the least restrictive ways possible and staff understood their responsibilities associated with the Mental Capacity Act 2005. People were supported with their meals and staff ensured they had access to regular drinks. Where people needed health and social care professionals the provider worked collaboratively with other agencies.

People were pleased with their regular staff and the consistency of care this provided when they had the same staff and described staff as kind, caring and helpful. People were treated with dignity and respect and their independence was promoted. Staff had a good understanding of the need to involve people in making choices and decisions about their daily needs.

People knew how to make a complaint if they were unhappy but did not always feel their complaints were listened to or resolved. There had been a high level of complaints related to call times and people felt these had not been addressed. There was some improvement to the management of complaints to ensure these were reviewed and acted on more consistently.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff suitably deployed to support people to stay safe in their own homes.

The arrangements for the management and recording of people's medicines were not clear and some people did not always receive their medicines as prescribed.

Care records did not always contain information about risks to people's health and safety.

Staff were trained to recognise signs of abuse but there was an inconsistent approach to recognising and reporting incidents to ensure people's safety.

Recruitment checks were usually undertaken and action taken to ensure people were supported by suitable staff.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had not all received the training they needed and competency checks needed to be strengthened to ensure staff used their skills.

People's rights were protected because staff understood and worked in accordance with the Mental Capacity Act 2005.

People were supported to choose and eat food that they enjoyed and staff were aware of signs to look for it people were at risk of losing weight or not drinking enough.

People were supported to maintain good health because they were supported to access health and social care professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had failed to ensure other aspects of the service were safe, effective, responsive and well-led. This meant people did not always receive a service that was caring and respectful of people's needs.

People did describe staff as caring and friendly in their approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not fully involved in developing or reviewing their support plans to ensure these were personal to them. Plans lacked details about aspects of people's care.

People were aware of how to make a complaint although often felt they had not been listened to. Improvements had been to the way complaints were managed and reviewed.

Is the service well-led?

Requires Improvement

The service was not always well led

The systems in place to monitor the quality and safety of the service were ineffective and did not ensure people received the care they needed.

People and their families were positive about the staff but did not feel the service was well led.

The new manager had sought people's views and was working to make the improvements needed.

The manager was demonstrating a more proactive style of management and was working alongside other agencies in order to improve the care people received.

Tipton Home 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.

Our inspection of this service in September 2016 identified that the provider was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. We found the provider had systems that were not effective in identifying the service's shortcomings and addressing these.

We inspected again in March 2017 to check that they were meeting legal requirements. We found that the provider had taken some action to address the breach of regulation in respect of governance of the service.. There were still further improvements needed though, because the size of the service meant the provider needed more time to embed effective systems of governance and the maintain improvements so that all people had their care calls on time.

Following our inspection of the service in March 2017, the provider we found the provider was not displaying it's performance rating at its office premises, and on its website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Criminal enforcement action was taken and a fixed penalty notice was served. The provider accepted liability for the offence and paid the required penalty.

This announced comprehensive inspection of Tipton Home Care Limited took place on 4 & 5 April 2018. The inspection team comprised 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. The Expert by Experience carried out telephone calls over a two day period to 15 people, and five relatives of people who were receiving a service.

The preparation for this inspection considered the information supplied to us by the provider in their Provider Information Return (PIR). This is information we require providers to send us to give some key

information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

We contacted local authorities who provided the funding for people to ask them for information about the service. We were informed that concerns had been identified by the local authority which were being addressed with the service and monitored. We also considered information available from other sources which included complaints shared with us by people who used the service.

During our inspection, we spoke with the manager, the human resources [HR manager] and eight staff. We met the provider on site but he was not present for the inspection or the feedback.

We looked at the care records for five people who used the service, eight people's medicine records, daily records, call log books, complaint records, safeguarding records, and records relating to the management and audit of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of September 2016 we found people did not receive their care calls at times they agreed with the provider, and staff were not always staying for the full length of the call. The provider took action to monitor and improve the consistency of calls and there had been a decrease in the level of concerns received by the care quality commission [CQC] about call times.

At this inspection the majority of people told us they had no concerns about staff staying for the duration of their call. Some people had experienced late calls, calls being too early or on occasion, calls being missed. The impact of this for some people varied. People told us it sometimes meant they were waiting for assistance with their personal care, or their meal, or waiting to go to bed or get up. Relatives told us calls times were not consistent with the times requested and sometimes not spaced out properly which affected their family member's daily routines. Whilst people and their relatives praised the staff who assisted them they felt staff were not deployed in a way that ensured their needs were met. People's comments included; "You never know for sure when the staff member is turning up". "I have asked for a late call, they are supposed to come at 9.50pm but they very often come much earlier; it's not good for my condition for me to be in bed too long". "They were very late; I had to wait till teatime to have a sandwich which isn't very good". Staff we spoke with said they had been asked to cover calls at short notice, this leading to late calls. Staffing levels were determined by the number of people using the service and the level of care they required. We found there had been a high turnover of staff which had caused some disruption to the deployment of staff.

The manager told us in response to this shortfall they were only accepting new care packages if sufficient staff were available to support people. We could not determine if calls were on time or for the expected duration as electronic and paper records did not accurately reflect the times and length of care calls. In addition we had received a number of complaints regarding call times from people and relatives. We found the manager was taking action to improve the deployment of staff and had been actively recruiting to staff vacancies. They were in the process of changing the electronic logging system so that staff had to log in and out of calls. This would mean the times/length of calls would be more accurate and could be easily monitored. Staff were also being deployed in teams to cover set geographical areas to provide more consistency and continuity for people. Although improvements were being made or planned, the impact at the time of the inspection was people did not always have the support they needed to keep them safe.

People we spoke with told us they were supported by their family members to take their medicines. Some people told us they managed their own with staff just getting them from the cupboard and providing a drink. Care plans did not provide a clear description of the level of support people needed to take their medicines. For example, in some people's care plans we saw entries such as, 'assist with medication' and 'apply cream' but there were no details as to the level of support needed. Daily records referred to medicines 'being given' and 'cream applied' but medicine administration records, [MARS] were either not in place or had gaps so we could not determine if medicines were administered by staff, or if they just assisted the person. This meant we could not accurately determine who had responsibility for ensuring people receive their medicines as prescribed. We saw the impact of inconsistent call times had led to one person missing their medicines on two occasions as the staff member had not prompted or assisted the person to take them. The manager had

ensured any missed medicines were reported to safeguarding and the staff member prioritised for re-training. The manager acknowledged shortfalls in the systems and told us they were reviewing the process to include risk assessments to identify the level of support people needed. We saw they had booked medicine training for all staff over the next few months to refresh their practice.

Risks to people's safety had been identified and staff we spoke with knew how to support people who were at risk of developing pressure ulcers, falling or who required the use of equipment such as a hoist to lift them. One member of staff told us, "We've had training to move people safely with equipment; we always have two staff for people who need the hoist". Whilst staff we spoke with could describe how to support people safely, records related to risks were not always updated. We found risk assessments lacked detail, were out of date or did not provide information referred to in the person's care records. For example a person's support plan showed their mobility had decreased and that they used a wheelchair, bedrails and had a catheter in place. There was no risk assessment to describe safe use of this equipment or how to provide catheter care. We saw a district nurse had been called out due to an issue with the person's catheter which showed staff needed more awareness of managing catheters. We fed these concerns back to the manager who told us they were reviewing people's support plans and risk assessments to ensure they contained up to date information.

We reviewed the recruitment records of five new members of staff and saw that the provider had conducted appropriate checks to ensure staff were suitable to support the people who used the service. We saw staff files had been audited to identify any gaps. In two of the five files we saw while a reference from the previous employer had been requested these had not been obtained. The Human Resources manager [HR] told us that as a precaution one employee remained on shadowing duties but there was no information regarding the second employee. Systems were in place to risk assess the suitability of employees where previous convictions had been declared. For example this would take account of the type of offence and when it took place. We saw the provider had acted on this by for example extending the probation period, carrying out additional spot checks and ensuring annual completion of declaration of offences. Staff we spoke with confirmed that other appropriate recruitment checks were completed before they started work. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

People we spoke with had no concerns about staff in relation to infection control or food hygiene. One person told us, "The staff are presentable and use good hygiene". Staff told us that gloves and aprons to prevent the spread of infection were available at the office. Training records showed that there were a number of staff who had not received infection control training. The manager told us that the high turnover of staff meant some staff had yet to undertake training which was being planned. Staff told us spot checks were carried out on their competencies which included checking they were wearing and using protective gloves and aprons. In addition people were asked if staff maintained cleanliness standards within their home.

People told us that they felt safe with the staff in their homes. Comments included; "I do feel safe with the staff they are very nice", and, "Yes I do they are as good as gold". Relatives had no concerns about people being safe with staff, one said, ""Yes I feel that [name of person] is very safe with them". Staff we spoke with were aware of recognising and reporting abuse or harm. One staff said, "Sometimes it might be the person is at risk because their house is unsafe, or we've noticed bruising but whatever it is we are always told to report it to the office". The manager had been in post for six weeks and had taken over responsibility for safeguarding. She had introduced a system for recording incidents and the actions taken. The manager had also introduced a system for staff to escalate concerns; records of which demonstrated she had an improved the overview of people who may be at risk of harm.

Requires Improvement

Is the service effective?

Our findings

People we spoke with were confident staff knew how to meet their needs. One person said, "I look forward to them coming and they do everything they are supposed to do". Another person told us, "The carers are excellent they are the back bone of the company". Relatives told us they were happy with the skills of staff but different staff caused inconsistency. One relative said, "The staff are fantastic; it would be nice to have the same ones".

People's needs were assessed prior to receiving a service and they confirmed that they were involved in this process, but the assessment process was not robust or consistent across the files we saw. There was a lack of personal history and some aspects of people's care had not been assessed or planned for. For example, assessments did not always contain information regarding people's medical conditions or guidance as to how these should be met. We also saw examples of where people's needs had changed but a re-assessment had not taken place to ensure their support plan reflected their current needs. We saw one person had been out of hospital for a few weeks but had not been re-assessed to see if their needs had changed. Two staff we spoke with described the person had developed difficulty in swallowing their medicines and had signs of a pressure sore. We saw from their records that risk assessments were out of date and did not cover these needs. We fed this back to the manager who arranged for a senior staff to visit the person that day to re-assess their needs.

Staff we spoke with said they had appropriate training and training records confirmed a range of training was undertaken. This included specific training to support staff with the skills needed to meet people's needs, such as dementia awareness and managing people's specific medical conditions; for example catheter care, stoma care, and pressure care. There had been a significant staff turnover. The manager said 75% of staff had left the service over the last five months. We saw correspondence from a district nurse regarding catheter care which indicated the staff member had a lack of awareness of how to manage this. There had been a number of medicine errors which questioned staff competency. The manager was aware that training and competency needed to be strengthened and we saw she had reviewed and prioritised staff training in key areas, for example a 12 week programme was underway for all staff in safe administration of medicines to ensure all staff had this training. The manager told us she was aware training for some staff was overdue and had plans to address this. Competency checks were being carried out to ensure staff used their training effectively.

Staff told us that they had completed an induction programme and shadowed experienced staff when they first started working at the service. The induction training was linked to the care certificate. This is a set of national care induction standards in the care sector which all newly appointed staff are required to go through as part of their induction. We saw certificates reflecting training undertaken on induction, but not all staff had evidence that a full induction had taken place. The manager recognised shortfalls in staff training and told us that they were updating records to ensure that all staff have an induction and are trained to the required standard. This would enable them to monitor staff development more effectively.

The Provider Information Return (PIR) stated that staff are supervised on a rolling program. Staff told us that

they had supervision where they reflected on their practice and identified areas for development. They also said that 'spot checks' were carried out to ensure they were working to the agreed standards. One staff said, "They will come out and check your uniform, ID and that you are using any equipment such as a hoist, safely". Staff files showed gaps in the frequency of supervisions but we saw plans were in place to address this, with staff now receiving supervision.

Most of the people we spoke with had their meals and drinks independently or provided by relatives. Staff we spoke with said where they supported people with meals or shopping they would always ask them about their choices. Staff said if people didn't want a meal they would ensure there was food prepared for the person to eat later and they left them drinks within reach to keep them hydrated. Staff were aware of signs to look for it people were at risk of losing weight or not drinking enough. Care staff told us if they had any concerns about people's eating or drinking they would report this to senior staff to ensure it was followed up. On the day of our inspection we saw two staff had alerted senior staff to a person who was experiencing difficulties in swallowing. We saw a senior staff member went out to visit and re-assess the person with a view to making a referral to the speech and language therapist (SALT) to ensure the person had the support they needed.

Staff told us they knew the people they supported well, and were able to recognise if they were ill. One staff member said, "I've done stroke awareness and would recognise if someone was having a stroke". Staff told us they would assist people in their own home to call their GP or report concerns to senior staff. Staff told us they had guidance as to what to do in emergencies and could phone seniors for immediate advice if they were concerned about someone. They said any changes to people's care were communicated to them, but care plans did not always show these changes.

Records showed that the provider had approached other health and social care professionals when people's conditions changed or they required medical support. The service offered an enablement contract for people who were supported for a short period following hospital care. We saw the manager attended a weekly meeting with the local authority alongside health professionals involved in people's care such as district nurses, occupational therapist and physiotherapists. This enabled them to discuss people's needs and identify appropriate on-going support when their enablement contract ended. This identified the support people needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this within the community, such as in people's own homes falls under the court of protection. We checked whether the provider was working within the principles of the MCA. The manager understood the MCA and the process and told us they would liaise with the local authority to request an assessment of people they felt required this protection. At the time of our inspection the service had not needed to make any applications to the Court of Protection.

Staff we spoke with understood people should make their own choices and staff were clear about the need to seek people's consent prior to providing care or support. A person told us, "They will call out to let me know they have arrived and ask if they can come in". Staff told us that they always checked with prior to care delivery if people consented. One staff member said, "Like the rest of us, people like choices and can change their mind so I wouldn't do anything without checking first". Staff recognised when people might lack

mental capacity and said they would escalate this to ensure family members, staff and other professionals could identify care which would be in the person's best interests.

Requires Improvement

Is the service caring?

Our findings

Whilst individual staff members were found to be caring, the provider's systems and processes did not always ensure that people's overall experience of receiving support was caring. A service that is not consistently safe, effective, responsive or well-led is not considered to be caring.

People told us they felt staff were kind and caring in their approach. We heard examples from people where staff made them feel at ease. For example one person told us, "Yes most of them are, [kind] they listen and ask me if I am ok especially when they cream my leg". People told us how they valued the fact that staff made time to listen to them. One person said, "We have a good relationship and I can tell them anything". Another person said, "I have a nice conversation with them".

People said their regular staff knew and understood their needs and preferences and they liked the staff who supported them. One person said, "My night bloke; he is great". Staff spoke about people with compassion and they knew people well. They told us they visited people on a regular basis so they got to know people and their families well. One staff member spoke to us about people they regularly supported and said, "I love talking to them, taking care of them, and if they are having a bad day I make sure I fuss them even more".

People did not always have the same staff and did not always know who was coming out to support them which caused them some anxiety. A person told us, "The carer in the morning is very good; most of them are good but I would have a better relationship if I had the same ones all the time". A consistent theme of people's comments was the poor communication from the service which left them feeling that they did not matter. One person told us they would welcome; "Better communication; let me know if they are running late, just let me know rather than me having to just sit and wait". People felt they had not been listened to when they had raised concerns about their call times being too early or late. One person told us, "I had a feedback form I mentioned about making sure I get my calls when I should due to needing to eat regularly, but I haven't heard anything". Relatives told us, "They never ring to say they are going to be late or even early and just arrive when they want". And, "The office don't let me know if they are running late I always have to ring them". People told us they often did not get a response back from the office. The lack of action by the provider did not show concern for people's wellbeing or a caring response to the people they were meant to support.

Staff were able to demonstrate how they involved people in expressing their views and making decisions. One staff member told us, "We speak to people all the time and often they tell us what they want or don't want". Another staff member told us, "People direct us; we have a plan but if people are tired, or want something different, we always try and do it". Staff told us that care plans provided some guidance about people's preferences and they tried to read these before meeting people. Staff provided examples of people being involved in daily decisions related to their routines and preferences and how they liked things done. This showed they supported people with expressing their views about their care. The manager showed us she was conducting home visits to speak with people about their care and support to ensure they were happy about how this was being delivered.

People were supported by staff to maintain their independence. Staff shared examples with us of how they respected people's skills such as making their own drinks, using their walking aids, taking their own medicines or dressing themselves. One staff member told us, "People like to do certain things independently and we respect that".

All of the people we spoke with commented that staff protected their dignity when delivering personal care. One person said, "They make sure they keep my dignity when they wash me". Staff were able to share with us examples of how they maintained people's privacy when providing them with care. One staff member told us, "I'd always cover people, close doors and make sure other family members were not around when delivering care".

Requires Improvement

Is the service responsive?

Our findings

People we spoke with were pleased with how staff responded to their needs within their own homes. People said that a care co-coordinator visited them in their home in order to discuss their needs.

People's support plans contained information about their care needs and the type of support they needed. However we found support plans were not always personal to the individual and often lacked information such as their history or specific information about medical conditions and how these should be managed. For example one care plan identified the person as being diabetic and their diabetes was diet controlled. The care plan stated, 'needs assistance with meals', but there was no details as to the type of assistance. The level of support people needed to manage their medication safely was not clear. Appropriate referrals had been made when people needed assistive technology and equipment to support them. For example we saw wheel chairs, hoists and slide sheets were in place to in response to people's physical abilities.

We saw that care plans did provide some guidance to support people in ways which took their individual needs into account. They had information regarding people's communication needs for people with a sensory disability. However this was not always followed to reduce barriers. For example staff we spoke with were not aware of a communication aid to support a person with a sensory loss even though this was in their support plan. They also confirmed this aid was not available in the person's home to assist the person to communicate effectively with them. In addition we saw in the person's file they had reported that new staff did not always communicate with them well and this annoyed them. This meant that staff were not always responsive to people's needs.

Most people could not remember having a review of their care package and those we saw were out of date. In addition support plans were not regularly reviewed or updated to ensure they remained person centred; focused on the individual. A staff member told us, "The support plans are not always up to date, and if we don't know the person this can cause problems in responding to their needs". Another staff member told us, "The support plans might not be up to date, but any major changes are communicated to us, which helps". Staff told us that they supported the majority of people on a regular basis and as such they knew their preferences and routines. This helped to ensure people had the level of support they needed with personal care, getting up and going to bed routines, mobility and meals.

Staff we spoke with told us the new manager had introduced a system for them to report changes in people's needs so that their care could be reviewed quickly. The manager acknowledged that the system of communication was poor. She showed us examples of emails sent by staff reporting changes and the action she had taken to respond to people's needs. One staff member told us, "I think things are improving".

People were not always supported by regular staff who they knew or who understood their needs. One person commented, "I have had my current carers for quite a long time and I have gotten to know some of them quite well so I want them to continue to support me". We saw examples of where care was not responsive to people's needs because their call was late, too early or missed out or the staff member was new to them. Irregular call times had impacted on people such as; waiting for meals, waiting to go to bed

and missing their medicines. Their care was often task-focused and did not consider their whole life needs.

People had access to a complaints procedure and contact numbers to reach the office if they were unhappy about their care. We found people's views varied as to how complaints were handled. People told us they had reported their experience of the care they received but did not always get a response. One person told us, "I complain all the time about the timings of my calls; ask to speak to the manager but he never calls back". Another person told us, "I complained once and the office sorted it for me".

Improvements had been made to managing and responding to complaints. Our review of these showed investigations were being carried out and feedback as to the outcome of people's complaints was being shared with them. We saw that there was a pattern of complaint themes related to call times, missed calls and where people had not received the care that they should have. We saw some action had been taken as a result of substantiated complaints. This had included an acknowledgement of where the provider had failed to respond to people's needs and there had been omissions in their care. For example, where a person due to late calls had not had the care that they needed. The manager told us they had taken action to re-enforce the importance of call times to all staff. We also saw updates to changes in people's care were emailed to staff so that where the support plan had not been updated; they had the information needed to deliver care. The manager also demonstrated that she had taken disciplinary action where people's care fell below the required standards. These actions were a positive response in terms of improving the quality of care to people.

Requires Improvement

Is the service well-led?

Our findings

The majority of people told us they did not think the service was well managed. People and their families told us they were concerned about the recent turnover of staff, late calls and poor communication with the management. They described their biggest issue as being the continuity of care.

We inspected this service in September 2016 and identified that the provider was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. We found the provider had systems that were not effective in identifying the service's shortcomings and addressing these. We inspected again in March 2017 to check that they were meeting legal requirements. We found that the provider had taken some action to address the breach of regulation in respect of governance of the service but further improvements were needed.

At this inspection we found the provider had continued to operate ineffective systems to audit, monitor and improve the quality of care and support people received. We found people's support plans, risk assessments and medication administration records had not been consistently completed or updated to reflect people's current needs. We found that checks on MARS were not consistently done to identify any errors. The manager advised that these would be implemented immediately. In addition some people had experienced late calls, calls being too early or on occasion, calls being missed. This had impacted on people's quality of life potentially placing people at risk of harm.

We found that the provider had failed to notify us in a timely manner about matters that needed to be reported to us. We saw the provider had delayed in sending notifications to the local authority and CQC. Additionally the provider had carried out their own internal investigation without local authority approval for two incidents which indicates the provider's lack of knowledge of safeguarding protocols. The manager explained these incidents had occurred before she commenced in post. Since that time the manager had taken appropriate action to ensure alerts and notifications were escalated to the appropriate authorities.

Although there is a new manager in post who is aware of the improvements needed, the provider had responsibility since we last inspected in March 2017 to continue to make the improvements but had failed to do so.

The provider has failed to comply with its legal obligations to us. This is a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service is required to have a registered manager and there was a registered manager in post. However they were not present during this inspection. It was the intention of the provider to appoint a new registered manager to improve standards. A new manager had been in post for six weeks and told us they intended to submit an application to be the registered manager.

We found that the manager had an understanding of providing care that achieves good outcomes for people. She was working on promoting a more inclusive culture by consulting with people and staff,

providing staff with direction and making improvements. Senior staff commented, "She shares her vision; she is a breath of fresh air. I'm feeling a lot more positive regarding support and I have support". We also heard the manager was, "Passionate about service users, expects excellent standards of care and is passionate about staff".

The manager had identified a number of areas for improvement and had prioritised staffing issues. The provider had invested in a new electronic rostering system which would allow them to deploy staff at the agreed times to people's homes. At the time of our inspection they were imputing the geographical areas and teams of staff to cover these areas. The system would allow them to monitor the duration of the call and alert them to any late or missed calls. They told us they hoped that this would promote consistency and reliability of their workforce.

We saw evidence that the manager had introduced a number of audit tools to check on the service delivery, these implemented prior to our inspection. For example a safeguarding tool had been introduced to enable the manager to review any safeguarding's that had taken place and to take appropriate follow up action. An audit tool for checking daily log books had been implemented which enabled the manager to check that any issues were picked up quickly and that staff were capturing the right information in their recordings. We saw a concerns tracker was in place to escalate any concerns to the manager on a weekly basis. Senior staff members were completing these quality checks to ensure the manager had an improved oversight of the service. Whilst these systems were not yet fully embedded they were being used to drive improvements. For example, the manager had met with staff individually to discuss expectations and responsibilities regarding staying in people's homes for the required duration of the call. The manager advised that people's support plans and risk assessments were being reviewed to ensure they contained up to date information about people's needs, and a clear plan about their agreed call times, this work on-going. The manager had been proactive and advised us that as part of the on-going improvements they were recruiting to an auditing and quality assurance post to commence within the month.

There had been an improvement in obtaining the views of people who use service, and staff. They had shared their opinions about the quality of the service via questionnaires. We saw these captured in detail people's experiences and the results had been analysed. The feedback identified a number of shortfalls such as call times and a lack of support and communication from managers. The manager told us there was 'no surprise' about people's feedback and we saw she had been proactive in developing an action plan to improve these aspects of the service.

We saw the manager was liaising with commissioners to support care provision. As a result of this they were reviewing their contracts in response to the demands on the service which was impacting on the quality of the service people experienced. As a result of this the manager and provider had reduced their intake of new care packages due to a lack of capacity. This showed a degree of transparency and partnership working to achieve the best outcome for people.

Staff we spoke with said that they had noticed some improvements since the new manager had arrived. They said that the manager was approachable and they had support. There was support from seniors on a daily basis when they needed this. Staff were aware of how to whistle blow if they were unhappy about people's care. This approach and these systems helped to support an open and transparent culture within the service.

The manager was aware of the duty of candour requirement and we saw that they had acknowledged to people where the care had fallen below standards. We also saw evidence of advising staff of expectations to mitigate any reoccurrence.

The provider had failed to display their performance rating on their website following our last inspection and we had taken enforcement action against them. Since that time and at the time of this inspection we found that the provider had ensured their performance rating was displayed on their website and at their location.

All registered providers are required on request to supply information about their service to us in a Provider Information Return (PIR). The provider had complied with this legal obligation.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We found the provider had ineffective systems to improve the quality of the service, and they had ineffective audits.