Proline Care Limited

Proline Care Limited - 4th Floor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 30 August 2017. The service is a domiciliary care service and provides care and support to 145 people in their own homes.

At our last comprehensive inspection in March 2017 the overall rating for this service was 'Requires improvement'. However, the service remained in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. Special Measures is a process whereby we expect the provider to seek out appropriate support to improve the service. We found that the registered provider had addressed some of the concerns that we had identified at our last inspection. However there were areas of further improvement required in respect of staffing levels, management of medicines and governance of the service. After our inspection in March 2017 we served a Warning Notice to the registered provider which required them to be compliant with this regulation by 14 August 2017. A Warning Notice is one of our enforcement powers. We asked the registered provider to send us an action plan to show how they would meet the legal requirements of the regulations.

We undertook this announced inspection on 30 August 2017 to check that the registered provider had followed their own action plan and to monitor their compliance with the legal requirements of the regulations. During this inspection we found some improvements, and effective plans to improve were in place to remove the service from 'special measures'. However, at this inspection, we found partial improvements had been made to meet the warning notice of Regulation 17. Further improvements were needed and we are considering what further action to take. The service continues to be rated as 'requires improvement', because, although some action had been taken, other actions had been planned, but not yet fully implemented.

There was a registered manager in post who was present throughout the inspection. 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.

Medicines were not consistently administered to ensure people's safely. People were not consistently protected from the risk of unsafe practice because risks assessments were inconsistent and staff did not consistently have sufficient guidance on how to support people safely. People told us that they felt safe with the staff who provided their care and support and that the staffing levels had improved following our last inspection.

People told us that staff sought their permission before providing care and support. However, we identified that the registered provider had not consistently understood their obligations under the Mental Capacity Act

2005. Staff had been provided with induction training and received training to update their knowledge and skills. People were supported by staff to prepare and cook meals when necessary. People were supported to access healthcare services as required.

People told us they were cared for by kind and thoughtful staff who knew their individual preferences and their likes and dislikes. Care was planned with the involvement of people who used the service. Staff maintained people's privacy and dignity whilst supporting them to remain as independent as possible.

Person-centred care plans had been developed to enable staff to provide care the way that people preferred. Staff spoke compassionately about the relationships they had developed with people they were supporting. There was an improved system in place to record and investigate complaints. People told us they were confident that concerns raised would now be addressed in a timely manner.

The quality assurance systems in place were not consistently effective and had not identified the shortfalls we had highlighted at our previous inspections. At this inspection, we found partial improvements had been made to meet the warning notice of Regulation 17. People and their relatives were encouraged to share their opinions about the quality of the service. Most staff spoke enthusiastically about the improvements already made in the quality of the service.

You can see what action we told the provider to take at the back of the full version 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.

People did not always receive their medicines as prescribed.

People's written care plans did not always record the actions staff should take to minimise their individual risks. However this risk was minimised as staff knew people and their needs well.

People were safe from the risks of abuse, because staff understood their responsibilities to keep people safe from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered provider had not consistently applied their responsibilities under the Mental Capacity Act 2005.

People were supported to eat and drink enough to maintain a balanced diet that met their needs and preferences.

People were supported to access other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and compassionate.

Staff promoted people's independence, by supporting them to make their own decisions about the care and support they required.

Staff knew people well and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning and

reviewing how they were cared for and supported.

The registered provider took action to resolve complaints in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Further improvement was required in the quality monitoring audits, to ensure appropriate action was taken to minimise risks to people's health and wellbeing.

Staff were encouraged by improvements the registered provider had made and were enthusiastic and motivated to continue to improve the quality of the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 30 August 2017 and was announced. The inspection was to follow up concerns identified at our last inspection. Prior to the first day of the inspection, the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff were available at the office to meet with us. We needed to ensure the provider could make arrangements for us to be able to speak with people who use the service, care staff and to make available some care records for review if we required them. The inspection team consisted of two inspectors and an expert by experience who spoke to people who used the service on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of our visit we reviewed information the provider had sent us in response to our last inspection which outlined the action they planned to take to comply with regulations. 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. This was received within the necessary timescale. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and in addition considered feedback provided to us by commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan what areas we were going to focus on during our inspection visit.

During the inspection we spoke with 14 people who used the service and 6 relatives of people. In addition we met and spoke with the providers' representative, the registered manager, one care co-ordinator, one field supervisor, one senior team leader, and 12 members of staff. We sampled some records, including eight people's care plans, four staff files and the way the provider had applied their recruitment process. We sampled records maintained by the service about training and quality assurance to see how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2017 we rated the registered provider as 'Requires improvement' in this key question and we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were placed at risk by the lack of clear systems and records to ensure that people who needed support received their prescribed medication as directed. The registered provider had not made the improvements required to ensure that this care and support was provided in a safe way and had failed to ensure that enough suitably skilled and competent staff were deployed to meet people's care needs as identified, especially with regard to care provided at the weekends. The registered provider had produced an action plan of how they would respond to these concerns.

At this inspection in August 2017 we found the provider had failed to ensure that the systems and records in place were sufficient. The necessary improvements required for the safe management of medicines had not taken place and therefore people could still not be certain they would experience safe medicine management. The service remained in breach of this regulation.

We looked at how medicines were managed by the service. Some people told us they received their medicines safely. One person we spoke with told us, "My carer will give me the tablets with a drink and then she writes in the records to say that she has seen me take them." A relative we spoke with said, "The carers can just give [mum] her tablets with a drink and once they have seen her take them, they write it in the records."

During our inspection however we found that medicines were not consistently administered to people safely. One person's care record identified that they required a medicinal pain relief skin patch to be applied to their body every three days. Records we viewed showed that the patch had been omitted on one day in June 2017 and one day in July 2017. Records we reviewed did not identify where the patches should be applied in line with the manufacturer's guidance. This practice put the person at risk of experiencing unnecessary pain and discomfort.

We looked for evidence that topical creams and eye drops had been administered as prescribed. We found significant gaps in the medicine administration records (MARs) for people. It was unclear if people had received their creams and eye drops or if it had been omitted at those times.
When medicines were not given as prescribed there was a system in place for staff to enter a code onto the MAR. Records were not clear and safe. We were unable to determine from the codes used on the MARs if prescribed medicines had been given, refused or omitted. This practice did not meet nationally recognised guidance.

On one person's care plan it stated they were allergic to penicillin, however, on the person's medicine records it stated 'no known allergy'. This put people at risk of being administered medicines which were unsafe for them to take. We received confirmation following our inspection that this had been rectified.

We were notified following our inspection by the provider that two people had been given medicines by the

agencies staff that had not prescribed for them. We requested further information about how the incident occurred. This incident had been investigated by other agencies who shared the outcome of their investigations with us. We will use this information to identify if we need to take any further action.

We looked at the management of medicines and found they had not been audited effectively. The audits had failed to identify the shortfalls we had found. The provider's representative told us that they were auditing 20 MAR's each month to ensure records were being completed accurately and to check that people were receiving their medicines consistently and as prescribed. However, the frequent gaps on the MARS had not been fully addressed by this process as we found errors were still re-occurring. Staff told us that they had received training to administer medication and competency assessments had been conducted to ensure staff were able to administer medicines safely. This training had not been effective at driving forward improvements needed in medicine management.

The registered provider was not ensuring the safe care and treatment of people through appropriate management of medicines and this was a continued breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 12.

At our last inspection in March 2017 we found people were at risk of not receiving the support needed to keep them safe and maintain their health. This was because up to date records had not consistently been made available for staff and the records available lacked detailed guidance about known risks.

At this inspection in August 2017 we found that individual risks to people's safety and well-being were being managed on a day to day basis. However, we reminded the registered provider we expected to see a continuous improvement to the records of risk assessments to ensure a consistent approach to mitigate risks.

We reviewed some people's risk assessments to ensure the care planned was appropriate and would protect them from the risk of harm. People told us that they were supported by regular staff who knew them well and who understood their individual risks. One person told us, "My carer has to let herself in using the key safe. I've always been a bit wary about it just in case anybody else was able to access it. My carer is very good though and will always ring the bell a couple of times before she puts the key in the lock and as soon as she is through the door… She always gives the door a loud bang on her way out so I know it's secure and that I'm safe, particularly overnight."

Staff knowledge of how to support people to minimise risks was evident in their explanations they gave us about how they managed risks. However, some of the records we reviewed were inconsistent. One person's care plan identified that the person required the support of specialist equipment to help them to transfer safely. We found detailed risk management plans with guidance for staff to follow to minimise any risks. On another person's care plan who also required the use of specialist equipment, there was no risk management plan available. We found that risk assessments were inconsistent and required further improvements.

At our last inspection in March 2017 we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that enough suitably skilled and competent staff were deployed to meet peoples care needs safely and appropriately as had been identified as necessary.

At this inspection in August 2017 we found that improvements had been made with regard to staffing levels at weekends and the registered provider was no longer in breach of this regulation. People told us that care

was delivered in line with their expectations and wishes. Most people told us that over the last few months the delivery of the service had improved. One person told us, "This has improved a lot lately. Firstly, now I've got regular carers they don't seem to run late very often these days, however if they are, I will either get a call from the carer herself to let me know what is happening, or the office will call me. I haven't had to call the office myself in quite some time to find out what is happening, so I am really pleased that they seem to have made a real change here." Another person said, "Weekends are now much better than they were earlier in the year. I now have two or three carers who I mostly see at weekends and I am happy with them. Timings too are better. They arrive more on time than not now, so I don't worry as much now." People told us that staffing levels had improved.

Out of the 12 staff we spoke with eight staff told us that staffing arrangements continued to be difficult at weekends. Staff described staffing levels at weekends as, "Weekends are hard because there are less of us", "Staffing levels are terrible at and poor levels at weekends" and "Weekends are a nightmare." Staff told us that despite poor staffing levels at weekends they did not rush people and still continued to deliver care and support the way people wanted it. We shared these concerns with the provider's representative who advised us that recruitment of new staff was still in progress and described how recent changes to staff Rota's had contributed to increased staffing levels at weekends. The providers representative told us they were aware of the inconsistencies in staffing levels at weekends and had already shared a proposal with staff to transform the weekend rota to ensure staffing levels were consistent and relevant to people's needs.

All of the people we spoke with told us that they felt safe and had no worries for their own safety or their personal items. One person told us, "With my regular carers coming now, they seem to be much better and arrive mostly within five to ten minutes of my call time. I certainly don't sit worrying about whether they're going to turn up anymore." Relatives we spoke with felt their relative was safe when they were receiving care and support from the service. One relative told us, "For myself and the family, it's knowing that mum is being visited four times a day and …….. making sure that she is safe and well."

Staff told us that they understood their responsibilities to protect people from risks of abuse and harm. They described different types and signs and symptoms of abuse. Staff we spoke with understood their responsibilities to report any concerns about abuse and told us they were confident to do so. A member of staff said, "I'd report any type of abuse to the office and if they didn't do anything about it I would whistle-blow to CQC [The Care Quality Commission]." The registered manager knew about their responsibilities to protect people from the risk of abuse. They had notified us when they made a referral to the Local Safeguarding Authority.

One relative we spoke with told us about a recent emergency her loved one had been involved in and said, "She [member of staff] also called the office and they called me, so that I could go over to mum's and be with her in time for the paramedics to check her over….I was very impressed because the carer had done exactly what she should've done in the circumstances." Staff we spoke with knew what emergency procedures to follow and knew who to contact in a variety of emergency situations. The service operated an out of hours on call system so that people, their relatives and staff had access to advice and assistance when the office was closed. Staff we spoke with told us they had undertaken training in emergency first aid. All the staff we spoke with told us that they had a responsibility to report and record all accidents and incidents.

Staff were recruited safely because the registered provider checked they were of good character before they started work for the agency. Records showed the registered provider had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017, we rated the registered provider as 'Requires improvement' in this key question. This was because the registered provider had not acted in accordance with the principles of The Mental Capacity Act 2005 (MCA). We identified that the systems in place to record staff learning and development were not up to date and that there was no effective system in place to monitor staff training needs or when refresher training was required. At this inspection in August 2017, we found whilst some improvements had been made, further improvements were 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.
We checked whether the service was working within the principles of the MCA. We found that staff asked people to consent to their daily care. People told us staff asked their permission before supporting them. One person told us, "I suppose my carers do ask me if I'm ready to have my shower in the morning. Sometimes if I haven't been awake very long, they will go and make my breakfast and tidy up in the kitchen while I come to… I'm usually ready to have my shower by then. If however, I really don't feel like a shower, they never force me to have one, and will just help me have a strip wash instead."

Staff we spoke with understood and acted in accordance with the general principles of the Mental Capacity Act. Staff described how they encouraged people to make everyday decisions, supported them according to their known preferences if they were unable to state their decision, and consulted with people's families or healthcare professionals to make sure decisions were made in a person's best interests. One staff member said, "I've had MCA training. Some people are unable to make decisions themselves and may need support in their best interests."

Some people's care plans included an assessment of their capacity. However, during our inspection we identified that the registered provider had not consistently applied their obligations under the Act. For example, one person's end of life plan recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that the appropriate documentation had not been completed and was not available in the person's care plan. The person's relative had made a decision on behalf of the person confirming that staff were not to contact emergency services should the person become unwell. There was no evidence to support that the relative had the appropriate authorisation to make this decision on behalf of the person. Following the inspection the registered manager advised us that this had been addressed and the person's end of life care plan had been updated. On another person's care plan we found that their relative had signed the consent to care on their records. We found evidence which identified the person had capacity to make their own decisions. The registered provider had not protected the person's rights to consent. Following the inspection the registered manager advised us that the person's care records had been updated.

People can only be deprived of their liberty so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. At the time of our inspection the registered manager told us that this did not apply to anyone currently using this service however they were able to demonstrate an awareness of the process to follow if required.

People and their relatives told us that they had no concerns about the staffs skills and their knowledge. A person we spoke with said, "I have to be hoisted a lot and I don't particularly enjoy it, but I think my carers have been trained well, they always talk me through everything that they are doing, they never lift me until I am happy and feeling secure and they continue to talk to me whilst they are negotiating round all the obstacles in my room. It's not an easy task, I can tell you." Another person told us, "My carers have had special training so that they know how to keep me safe when I'm having a seizure."

Staff told us that access to training to support them in their role was overall good. Staff told us they received training that reflected people's needs and enabled them to support people safely and effectively. Staff's practice was observed by senior colleagues to check they used their training to support people effectively. Staff consistently told us their knowledge and learning was monitored through supervision meetings and unannounced 'observation checks' on their practice. A member of staff told us, "I have regular supervisions, spot checks and competency checks with [name of staff member]. She's red hot."

Staff told us they felt prepared to work with people because they had training during their induction to the service. They told us when they started working at the service, they observed experienced staff and got to know people, so they could understand their individual needs and abilities. A member of staff told us, "I had two weeks of shadowing other staff before I started on my own. I've had so much support and I'm doing the Care Certificate now." Records showed new staff completed a training programme designed to meet the fundamental standards of care in accordance with the Care Certificate [A nationally agreed set of fifteen standards that health and social care workers follow in their daily working life].

Some staff were involved with food preparation in people's own homes and supported people with their dietary needs. One person told us, "At lunchtime when my carer comes in, she will make me a microwave meal to have…she will make me a sandwich that she will just put in the fridge so that all I have to do at tea time is take it out and unwrap it. She always asks me what I would like in my sandwich and if I can't remember quite what I've got in the fridge, she will let me know what there is and then I decide." Staff we spoke with told us they had completed food hygiene training to ensure the food they prepared was safe for people. Staff were knowledgeable about people's dietary requirements and care plans we sampled contained information about people's health conditions which could be affected by their diet.

People told us that generally they managed their own appointments with health professionals. Records showed people were supported to access to healthcare specialists, such as opticians and district nurses, when needed. One relative told us, "Mum was having some very bad urinary infections but her regular carers now take great care of her catheter and the bags and she has been infection free for a few months now thanks to their perseverance." Staff told us that they felt they had the knowledge and skills to look after people's health needs. A member of staff told us about a recent health concern for one person and said, "I let the office know straight away."

Good

Is the service caring?

Our findings

At our last inspection in March 2017 we rated the registered provider as 'Requires improvement' in this key question. At this inspection in August 2017 we found improvements had been made.

At our last inspection in March 2017 people, their relatives and staff told us that staff changes were often made at short notice and that they did not receive support from consistent staff as regularly as they would wish. Most of the people we spoke with voiced their concerns about the staffing levels and changes of staff at weekends, they told us they did not have regular staff and could not always be sure when and who would be coming to see them.
At this inspection in August 2017 people and relatives told us they had been pleased with how care had been delivered since our previous inspection. One person told us, "We've been really pleased with the fact that most of the time the carers now get here within 10 minutes of the call time and it's made it much easier for us to be able to plan to do things later on in the day, knowing that we will be ready by a certain time each morning." One relative said, "I know that mum used to always worry that when the carer was running late they weren't going to turn up at all, so she would always be phoning the office to try and find out what was happening. However, of late, she's told me that she's had very few really late calls and when this has happened, the office have actually called her, or the carer themselves has called her to let her know what is happening so that she hasn't had to worry that she was going to be missed out."

People told us staff were kind and caring. People's comments included, "Some carers are exceptional and will do absolutely anything to make sure I'm comfortable and happy" and "I've never had anybody shout at me or use bad language and the carers have always been very friendly and kind. I like the fact that I can have a bit of a chat with them, and if they have time they will always sit down and have a couple of minutes with me before they leave to go to the next client."

People who used the service told us they were now supported by regular staff and this had enabled them to develop positive relationships with them. A relative told us about the care their loved one received and said, "The carers…in my experience have always been very kind to her and they put up with her little funny ways and never say anything back to her when at times, she can be quite unpleasant." Staff told us that they supported the same people on a regular basis which enabled them to get to know and understand people's preferences and to gain their confidence and trust.

People told us they were involved in making decisions about their own care and support needs. We saw that people had signed and agreed their care plan. The service had enabled people to voice their opinions about how they wanted their care and support provided. One person described how they still lived together with their loved one and said, "Living here in our family home [we] are still able to make decisions about our lives even at this time and our family know that we are being supported to stay safe." A relative told us, "We only started with the agency probably two or three weeks ago when my dad came out of hospital. He was visited in hospital by someone from the service and she was able to chat with him about what help he needed coming home and also when he wanted the carers to come and how he wanted the jobs divided out. As far as he's concerned, he's been thoroughly involved in organising his care."

People told us that generally care visits were arranged for specific times of the day that suited their preferences to get up, to eat and to go to bed. Staff described ways in which they encouraged people to make a range of choices whilst supporting them, for example, the choice of clothes and food. One staff member told us, "I offer people choice in what they want to wear, what they want to eat. We are there to support and not take over. They have the rights to choose what they want in life." Records we reviewed contained information about people's likes, dislikes and individual preferences. For example, one person's care record stated issues of importance to the person and included information about the person's pets, the person's religion and how they were to be supported with making choices about the clothes they wanted to wear.

Staff told us that they had received training in equality and diversity and understood the importance of respecting people's beliefs, values and cultural needs. We saw that the service had supported people to express their individual preferences for care. People had been asked for their preferences for male or female carers and the service had accommodated their requests. One person told us, "I think I was also asked whether I preferred male or female carers."

People were supported by staff who understood the importance of maintaining people's privacy and dignity and promoting their independence. One person told us, "In the evening when my carer comes in, the very first thing she does is close all the curtains and put some lights on so that no one can see in. The curtains always stay closed in my bedroom until I am up and totally dressed in the morning and again the carers would never think of starting to undress me without the curtains being shut at night." Staff shared examples of how they worked to maintain people's privacy and dignity. One member of staff said, "I keep [people's] body covered and don't expose parts of the body and always get consent." Staff told us that when managers undertook spot checks they looked at their ability to work in ways that promoted people's dignity. This demonstrated that there were systems in place to ensure staff were treating people with dignity and respect.

People told us that the staff maintained confidentiality. One person said, "The carers are like members of my family now and we usually just have a general chat about anything that's going on in the world or they'll ask me about my family. They've never really talked about their job and I've never heard them talk about any other clients they look after." Another person said, ""Oh goodness, we're always far too busy catching up on what's going on in the soaps on the television rather than the carers ever talking about their jobs or other clients they look after." Staff we spoke with described the importance of ensuring that people's rights to confidentiality were maintained and shared examples of how they put this into practice.

Good

Is the service responsive?

Our findings

At our last inspection in March 2017 we rated the registered provider as 'Requires improvement' in this key question. We found that the service did not provide a seven day service that gave continuity of care to people. Some people we spoke with told us that the registered provider had not been responsive to their request to change aspects of their care. Some people told us that they did not feel that their concerns were responded to properly or listened to and on occasions their concerns had not been addressed. At this inspection in August 2017 we found improvements had been made.

People told us that they were supported by a consistent staff team who had a good understanding of their individual needs and preferences. One person said, "To be honest, it's probably taken 18 months to get to a point where I now have regular carers but it is so much easier as I kept telling the agency during that time, because now they've had the opportunity to spend time with me and know how I like things to be done." Another person told us, "Last year I complained about not having regular carers either during the week or at weekends. The situation has improved drastically now and for the last two or three months I have had both regular carers during the week and at weekends. I am confident that if I had any problems in the future, the manager would listen to my concerns and do something about it." Staff described people's individual needs and how to meet them. They told us about people's preference when delivering personal care, their food and drink preferences and were able to describe people's daily routines and life experiences.

People's needs were assessed at the start of the service and we saw that people had contributed to the reviewing of their needs. One person told us, "I've been with the agency for a long time now, but I do remember sitting down and speaking for some time with a manager from the service and we chatted about what help I needed and when I would like the care provided." One person told us, "My wife usually has someone come and visit her roughly every six months when they talk about her health, the care provided and any changes needed." Care records that we sampled were written from the point of view of the person receiving care. They were recorded in ways which ensured staff knew how to provide care in the way people wanted. For example, we saw specific guidance for staff stating, 'Please dress me in the clothes I have chosen, 'I do not like sea foods and 'I like fresh orange juice.' People told us that the service was responsive to their feedback about their care. One person told us, "I don't need to phone the office very often, just to cancel a visit if my son is visiting or to change the time if I have a doctor's appointment come through. As far as I can recall, the phone has always been answered and they've always been very willing to help me out so that I don't miss any appointments." One relative shared with us, "We have had a couple of conversations with a manager about carers who perhaps haven't quite fitted in with mum and how she likes things to be done. In both instances, the carers were replaced by other carers who are now both still working with mum."

A person who used the service told us, "Carers write every day to confirm what they've been doing." Staff kept daily records at people's homes of how people responded to care and about their health and well-being. Staff told us the daily notes were used to ensure effective communication between staff members and that daily records were used to facilitate continuity and to provide the best possible outcome for people. One member of staff told us, "I always read the previous carers notes to make sure everything is okay."

The services complaints and compliments policy was made available to people through a service user handbook which was provided to people and their relatives when care commenced. We looked at the services complaints logs and could see people understood how to make a complaint. One person told us, "I would certainly have a conversation with one of the managers if there was anything in particular that I wasn't happy about, and I think from conversations I've had in the past, that they would listen to me and take my problems seriously and do something about them." One relative said, "I keep another copy of the complaints leaflet here with me because I asked for an extra one when we met with the manager before mum's care started. There's also a copy in mum's folder that she keeps at home." We saw evidence that complaints had been investigated and responded to in line with the provider's policy. We saw that the registered provider had captured informal complaints to drive improvements in the quality of the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in March 2017 we rated the registered provider as 'Inadequate' in this key question as they were in a continued breach of the regulations related to the governance of the service. We identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the registered provider had started work to address the areas of improvement as identified in their action plan, some actions were still outstanding or had not been completed as had been planned. The registered provider remained in breach of this regulation as they had not taken the action required to ensure that effective systems would be in place to assess and monitor that the service would consistently deliver high quality, safe care. The management, leadership and governance of the service had not been effective. We served a warning notice to the provider requesting them to be compliant with this regulation by 14 August 2017.

During this inspection in August 2017 we found that action had commenced or been taken, but that this had not been adequate, effective or timely enough to drive forward all of the improvements required. For example, we found that monthly audits of care files had been completed but they had not identified the shortfalls in care and support that we had found as identified within the safe, effective and well-led sections of this report. Some of the care plans we looked at did not consistently include detailed risk assessments, or detailed explanations for staff about how to support people safely. There were inconsistencies in the completion of medicine records and the failure to safely administer medicine. Whilst some issues had been noted they had not consistently been acted on. The systems in place had not identified that some guidance associated with people's health conditions were general and did not consistently reflect people's individual needs. We did note that one member of staff had not received the required supervision and competencies observations. Our discussions with the registered provider identified that that the governance arrangements had not identified this. They were not aware of this issue and advised they would address this following our inspection. The provider's representative acknowledged and agreed with the concerns noted during this inspection.

These issues regarding good governance of the service were a continued breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

People and their relatives told us the quality of care was, "Improving ". One person told us, "We've only been with them a couple of months, but from what we've experienced so far, we've been very impressed. Yes, we would recommend them. A friend recommended them to us." A relative said, "I used to get rung up by mum at weekends when no carer had arrived, but this has settled down now and as far as I'm aware, she hasn't had a missed call in months. She tells me that she has carers now who come every weekend and I understand that they are usually on time, or thereabouts, which is a great improvement."

Improvements had been made in the management and oversight of staff. One member of staff told us, "There's been a hell of a lot of changes for the better." Staff we spoke with told us they felt supported to do their job and that they had plenty of opportunity to talk about their practice, raise any issues and ask for guidance. Records showed that staff had received regular one-to-one meetings, spot checks and

observational competencies and had scheduled regular meetings in future. Staff told us their one-to-one meetings were useful and had identified what they could do to improve their practice.

At our last inspection in August 2017 staff we spoke with were knowledgeable about how to raise concerns; however, they were not confident that the management would address these in a timely manner. Staff told us improvements had been made. One member of staff told us, "I feel more supported by the management team, It's a lot better." The majority of the twelve staff we spoke with told us that they felt more supported by the office management team. We found that the main issues communicated to us from staff were around staffing levels at weekends.

We saw that improvements had been made with staff training records. However, more improvements were needed to ensure the training records were consistently robust. For example, the provider's representative confirmed that the training records presented to us on the day of the inspection w were not completely up to date.

Improvements had been made in staffing levels. People consistently told us that following our last inspection they received care and support from a consistent and reliable team of staff and were supported in a way they needed without feeling hurried. One person said, "They are a lot better now. I have regular carers who I like, they arrive on time and now weekends are not a worry as I have regular carers then as well, so yes, I would recommend them now."

Improvements had been made in the systems required to monitor accidents, incidents and complaints records. We saw a log of each incident that documented whether the action taken by staff on each occasion was appropriate and effective in supporting the person afterwards. There was an analysis of the information to identify any patterns, causes or triggers and whether they were unique to the person or caused by the environment.

The registered provider's policies for obtaining feedback from people and their relatives included surveys, regular telephone calls and care plan review meetings. One person who used the service told us, "I'm fairly certain that I've filled in at least a couple of surveys about the service. I couldn't tell you about the results though as I don't remember hearing any more about them." Another person told us, "I also have regular meetings with a manager when we talk about the care being provided at the minute and whether I am happy with the service or whether my needs are changing and I need some additional help. I think to be honest; I couldn't be much more involved than I am at present." One relative said, "A lady called [name of staff] usually does our review meetings and if I need to talk to anyone about Mum, I will usually ring her. I've never had problems talking to her and she's always sorted any issues out for us." We saw an example of a concern that had been raised by a person who used the service. We noted this had been responded to in a timely manner and saw that weekly telephone calls had been made until the issue had been resolved to the person's satisfaction. We did not see evidence that the most recent survey results had been analysed to sort out the priorities for action and to drive continual improvement.

The registered provider demonstrated understanding of their responsibilities as a provider of a regulated service. For example, they had displayed the latest CQC rating conspicuously within their office. Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that notification systems were in place and that staff had the knowledge and resources to do this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring the safe care and treatment of people through appropriate management of medicines. Regulation 12 (2) (g)