

Nestor Primecare Services Limited

Allied Healthcare Hull

Inspection report

Unit 5, Marfleet Environmental Industrial Park
Hedon Road
Hull
North Humberside
HU9 5LW

Tel: 01482798669

Website: www.nestor-healthcare.co.uk/

Date of inspection visit:

01 December 2016

02 December 2016

Date of publication:

11 January 2017

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

Allied Health Care Hull is registered to provide personal care to people in the community.

This unannounced comprehensive re-rating inspection took place on 1 and 2 December 2016. At the comprehensive inspection of the service in June and July 2016, we found the registered provider was non-compliant with regulations 9, 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This meant the registered provider was not meeting the requirements of regulations pertaining to providing person centred care, obtaining appropriate consent and following the principles of the Mental Capacity Act 2005, providing safe care and treatment, safeguarding people from abuse and improper treatment, responding and acting on complaints, utilising effective systems to monitor and improve the quality of service provision and ensuring suitable numbers of staff who had completed relevant training and were supported effectively could be deployed to meet the needs of the people who used the service.

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

At this comprehensive re-rating inspection on 1 and 2 December 2016 we found the registered provider had taken appropriate action to achieve compliance with all of the regulations previously identified as non-compliant during the comprehensive inspection in June and July 2016.

At the comprehensive inspection of the service in June and July 2016, we found that people did not always receive person-centred care this was due to 160 care plans being out of date and not accurately reflecting the care and support people required. During this inspection we found that people's care plans were up to date, reflected their current needs and provided appropriate guidance to enable staff to deliver person centred care in line with people's preferences. However, we also found staff failed to deliver care at pre-arranged times which meant people did not always receive support in line with their preferences.

At the comprehensive inspection of the service in June and July 2016, we found people had not always provided consent to the care and support they received. People and friends and relatives had provided consent without the appropriate authorisation to do so. During this inspection we saw consent had been gained and recorded effectively and the service was working in line with the principles of the Mental Capacity Act 2005.

At the comprehensive inspection of the service in June and July 2016, we found people did not receive safe care and treatment. Risks to people's safety were not mitigated and staff delivered care and support that had not been planned for or risk assessed. During this inspection we saw evidence that reviews of people's

care had been undertaken, new care plans and risk assessments had been developed, which included pertinent information to ensure staff could deliver care and support safely.

At the comprehensive inspection of the service in June and July 2016, we found people were not safeguarded from abuse and improper treatment by way of neglect. This was due to the service not being able to deploy sufficient staff to deliver the care and staff leaving care calls consistently early. During this inspection we saw evidence to confirm additional staff had been recruited and call monitoring information showed staff stayed for the full duration of the care call.

At the comprehensive inspection of the service in June and July 2016, we found complaints were not always responded to and investigated appropriately and complaints were not used to improve the overall quality of the service. During this inspection we saw complaints were acknowledged, investigated and responded to in a timely way. Responses to complaints were reviewed by senior managers to ensure they covered all areas of concern and were used to drive improvement whenever possible.

At the comprehensive inspection of the service in June and July 2016, we found the registered provider's governance systems were inadequate and not operated effectively. During this inspection we saw evidence to confirm internal systems were monitored and used to ensure specific actions had been undertaken when required, such as reviewing people's care and support, updating care plans and delivering staff training and support. However, the system required further development to enable it to drive improvement and ensure consistency across the service.

At the comprehensive inspection of the service in June and July 2016, we found suitable numbers of staff could not be deployed to meet the assessed needs of the people who used the service. Staff were not supported effectively and had not always completed refresher training when required. During this inspection we saw evidence to confirm all staff had completed refresher training in line with the registered provider's policy and received effective levels of supervision, appraisal and mentorship.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We saw improvements had been made and in this area, however, we could not rate the service higher than requires improvement for 'safe' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

People who used the service were supported by staff that were deployed in suitable numbers to meet their assessed needs.

Appropriate action was taken to mitigate known risks.

People received their medicines as prescribed.

Requires Improvement ●

Is the service effective?

We saw improvements had been made and in this area, however, we could not rate the service higher than requires improvement for 'effective' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Staff had completed relevant training and were supported to deliver effective care and support.

Consent was gained before care and support was delivered. The principles of the Mental Capacity Act 2005 were followed.

Requires Improvement ●

Is the service caring?

We saw improvements had been made and in this area, however, we could not rate the service higher than requires improvement for 'caring' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

People who used the service were supported by small dedicated teams who knew their needs and understood their preferences for how care was to be delivered.

Staff were enabled to deliver person centred care to the people who used the service.

Requires Improvement ●

People told us they were supported by caring and attentive staff.

Is the service responsive?

We saw improvements had been made and in this area, however, we could not rate the service higher than requires improvement for 'responsive' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

People's care plans were updated after reviews of people's care had taken place to ensure staff were fully aware of people's needs.

Complaints were investigated and responded to in appropriate timescales. The service used complaints to improve the quality of care when possible.

Requires Improvement ●

Is the service well-led?

We saw improvements had been made and in this area, however, we could not rate the service higher than requires improvement for 'well-led' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

The registered provider's quality assurance systems were used to ensure, amongst other things, people's care plans were up to date, staff training and one to one support had been completed, complaints and accidents and incidents had been investigated. However, further improvement was required to enable them to effectively drive quality.

The registered manager notified the CQC of specific events that occurred within the service as required.

Requires Improvement ●

Allied Healthcare Hull

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 registered provider was 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 ensure improvements had been made since our comprehensive inspection in June and July 2016, as well as provide a rating for the service under the Care Act 2014.

This unannounced comprehensive re-rating inspection took place on 1 and 2 December 2016. It was carried out by an adult social care inspector. Before the inspection, we contacted the local authority commissioning and safeguarding teams to gain their views on the service. We reviewed all of the information we held regarding the service including notifications and previous inspection reports.

During the inspection, we spoke with 12 people who used the service and three of their relatives. We also spoke with the registered manager, the service deliver manager, a care delivery director, two care co-ordinators, a field care supervisor, a care delivery trainer and six members of care staff.

We looked at ten people's care plans along with the associated risk assessments and Medication Administration Records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included action plans, call time monitoring figures, recruitment information for seven members of staff, staff training records, staff supervision and appraisal records as well as internal auditing and quality assurance information.

Is the service safe?

Our findings

People who used the service told us they felt safe with the staff who supported them. One person said, "I do feel safe, I know who is coming to help me and I feel safe because I don't have strangers coming in my house." A second person told us, "I'm safe, I can't do certain things anymore, I need their help to get washed and dressed if I tried it myself I think I would do myself a mischief." Another person said, "Being at home is the safest place and I couldn't be here without the carers coming every day."

A relative we spoke with said, "It's brilliant to know mum has carers going in every day. I used to pop in just to check on her, but don't have to do that as often because someone [a carer] goes three times a day now." Another relative said, "I don't know what we would do with them [the carers] coming. I couldn't look after [name of the person who used the service] by myself."

At our comprehensive inspection in June and July 2016, we found the registered provider had failed to ensure the service delivered safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 12 described above. This meant that the service was compliant with Regulation 12.

At our comprehensive inspection in June and July 2016, we found that the registered provider was not aware of people's current care and support needs and had subsequently failed to mitigate risks in relation to people's care; people did not always receive their medicines as prescribed; the registered provider did not have safe and effective plans to respond to foreseeable emergencies and safe recruitment procedures were not followed.

We also found that 160 people's care plans had not reviewed for over a year, which meant the registered provider was not aware of their current care and support needs and had subsequently failed to mitigate risks in relation to their care.

Risks were not managed to ensure people's safety, care plans failed to record all of people's individual care needs and their log books [records of what care and support staff had provided] evidenced that staff were delivering support that had not been planned for or risk assessed. One person required the use of a hoist to ensure they transferred from their wheel chair to other areas of their home safely; staff recorded in their log books that they had used the hoist, but the person's care plan failed to stipulate their moving and transferring needs and no risk assessments were in place to ensure transfers were completed safely.

Risk assessments of people's properties were conducted when their care package commenced or when their care was reviewed. One person's assessment had been created in March 2014, but had not been updated when they moved new to a new property. It was not clear from the registered provider's records when the person had moved but when a review was completed in July 2016 it was evident the risk

assessment in their file was in relation to their old property. This meant the specific risks regarding the new property had not been assessed or mitigated.

During this inspection we saw that the registered provider had ensured every person who used the service had an accurate and up to date care plan in place. Reviews of people's care had taken place and their care plans and risk assessments were updated to ensure staff were aware of their current care and support needs, how they preferred their support to be delivered and how to mitigate and reduce known risks.

A member of staff we spoke with said, "All the paperwork is so much better. Everything is up to date, the care plans are accurate and the risk assessments are clear and easy to understand." The field care supervisor explained, "Whenever anyone's needs change or if they have had a long stay in hospital I go and review them to make sure we have all the information we need and the care plan is accurate."

At our comprehensive inspection in June and July 2016 we reviewed eight people's Medication Administration Records (MARs) and found five that included gaps in recording or contained other errors. The registered provider's IT systems showed that 99 people required a MAR audit [this was because they had not had their MARs audited for at least three months]. This meant that the service had not assured themselves that people were being administered their medicines as prescribed.

During this inspection we saw evidence to confirm every person who used the service had received a MAR audit in line with the registered provider's policy. This meant the service was actively reviewing the administration of medicines to ensure people received their medicines as prescribed. When errors occurred there was evidence to show that staff had been contacted to ascertain the reason and action had been taken as required to minimise future occurrences.

We reviewed over 20 MARs and saw that they were completed accurately. When omissions were made staff had included information explaining why. A member of staff said, "The field care supervisor does spot checks more now so they look at how we give medicines. It's good because if I'm not doing something right I want to know they will pick it up." The field care supervisor commented, "I review them [the MARs] every three months and sometimes more regularly depending on when they come. If the staff have made any mistakes I find them and contact them to find out why, if we recognise a problem we can do more spot checks or bring them [staff] in for re-training."

People told us staff supported them to take their medicines as prescribed. One person commented, "I need the carers to help with my medication, I can't do it myself anymore I can hardly see the label let alone read it." Another person said, "I do look after my own medicines, the staff do check to make sure I have taken them but I am going to ask them if they can do it all for me, I think I would find that easier."

At our comprehensive inspection in June and July 2016, we found the registered provider did not always follow safe recruitment practices. The registered provider's referencing policy stated, 'A minimum of two references will be sought, however, where it is not reasonably practical to delay the offer of employment further, a decision will be made to proceed with one reference.' We found checked 10 staff files and found seven people only had one reference in place. We found that some people's references were not from their most recent employer or a professional reference. Failing to ensure suitable references have been returned to the service before offering prospective staff a role within the service exposed people who used the service to the risk of receiving care and support from staff who were not suitable to work with vulnerable adults.

During this inspection we reviewed seven staff files and found that all except one contained two references and other appropriate checks. The registered manager explained, "We will always get two references and

make sure they are from their [the prospective member of staff] last employer. If we only have one reference in the files now that is because they have worked for us for so long now that we have assured ourselves about the character and have no issues with their work."

Disclosure and Barring Service (DBS) checks were undertaken. A DBS check is completed during the recruitment stage to determine whether an individual has a criminal conviction which may prevent them from working with vulnerable people. The registered manager told us the registered provider re-applied for all staff's DBS checks on a three yearly basis. They said, "Everyone will have a new one applied for and if anything [a criminal conviction] is highlighted we will decide what action to take."

At our comprehensive inspection in June and July 2016, we found that the registered provider had failed to ensure plans were in place to deal with foreseeable emergencies. The registered provider's business continuity policy stated each service would have completed a business continuity planning form and required 'all of the contact numbers to be checked quarterly and that the plan would be tested annually using different disaster scenarios'. When we asked the registered manager to provide us with the business continuity plan it was not available and it became apparent one had not been created.

During this inspection we saw that a business continuity plan had been created, which helped to ensure people who used the service would receive safe and effective care before, during and after emergency situations.

At our comprehensive inspection in June and July 2016, we found the registered provider had failed to ensure the service could deploy suitable numbers of suitably qualified, competent, skilled and experienced staff to deliver care and support to the people who used the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 18 described above. This meant that the service was compliant with Regulation 18.

At our comprehensive inspection on in June and July 2016, we found that during the period from 27 June to 3 July 2016 [seven days] the service could not deliver 430 care calls and had to request that the local authority commissioners found alternative arrangements to ensure they were covered. The registered manager told us, "We have exhausted all of our options; we have had to hand back calls [care packages] to the council [local authority commissioners] because we didn't have the staff."

The registered manager informed us the service required 30 new care staff, which included 22 staff to work during the evenings and at weekends to ensure they could fulfil all of the care packages that they had been commissioned to undertake. They said, "We have eight new staff who need to have an induction but they are not just for nights and evenings so we need to hand some people back permanently. We just do not have the staff to deliver the care when they need it." The care delivery director explained, "We have had to hand back the people whose regular staff have left because we need to recruit, induct and train staff and we just can't do that quickly enough." 17 people who received a service predominately requiring two care staff and up to four calls each day, had to be re-allocated to another service on a permanent basis by the local authority commissioners to ensure their needs were met safely and consistently.

During this inspection we saw evidence to confirm suitable numbers of staff were employed at the service. We reviewed call monitoring data held within the service and saw that there had been no missed calls for over four months. The care delivery director told us, "We targeted our recruitment so we brought staff in who

could work evening and weekends, which was where we had the problem. We will continue to recruit so we have a pipeline of staff to bring in when we need them, I won't let the same things happen again." The registered manager commented, "We don't have enough hours [of work] for the staff we have now, they have gaps in their rotas which is something we monitor constantly."

Staff we spoke with told us that they were no longer asked [by the service's care co-ordinators] to regularly cover calls at short notice. Their comments included, "I know what my rota is week on week so I can make plans at home and not have to let people down", "I know the people I am supporting and I don't have to leave my calls earlier to get to someone else's because the office staff need it covering" and "I want more hours but that will happen, what's important is we know where we are going and who we are going to see." The care delivery director described the service's model of core care teams. They said, "I want everyone to have a small team of dedicated staff, it is the best thing for continuity of care and enables staff to recognise early warning signs [a deterioration in a person's health and general well-being]."

At our comprehensive inspection in June and July 2016, we found the registered provider had failed to safeguard people who used the service from abuse and improper treatment. This was because they had failed to consistently record and investigate accidents and incidents, meaning that effective learning was not taking place and consequently preventable accidents and incidents could re-occur. The registered provider had also exposed people to the risk of abuse by way of neglect because they had failed to ensure the service could deploy sufficient numbers of staff. They could not deliver care to 148 people from 27 June to 3 July 2016, and had to permanently cease supporting 17 people because they could not meet their needs. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 13 described above. This meant that the service was compliant with Regulation 13.

We saw that 96 accidents and incidents had been recorded in the last four months. The registered manager explained, "It was about re-educating the staff, what needed to be recorded and what was an incident" and "The senior management review the incidents and feedback to us any actions that need taking or request further information if its required." We saw that each incident was investigated as described and appropriate action was taken to reduce the possibility of any future re-occurrence.

Records we looked at confirmed the service could deploy 86 members of care staff to meet the needs of the 147 people who were actively using the service. This meant that people who used the service were no longer exposed to the risk of neglect because the service has suitable numbers of adequately trained and experienced staff to meet their needs. The service had consistently reduced the deficit in care hours and at the time of our inspection it was at 5%. This meant the service were commissioned to deliver 1530 hours of care and delivered 1451. The registered manager told us, "If someone cancels their call that adds to the deficit, if someone is in hospital that does as well, the rest is when staff have leave calls early at the request of the client or their family."

The registered manager also told us how the service had worked with the local authority commissioners to reduce the time length of 32 care packages where staff were consistently asked to leave early. They explained, "We have reduced some of the medication only calls from 30 minutes to 15, because people didn't need the staff to stay for 30 minutes when they just needed help to take a couple of tablets." This meant the registered provider was deploying staff more effectively in order to meet people's needs.

Is the service effective?

Our findings

People who used the service told us they were supported by capable and competent staff who delivered care and support effectively. Their comments included, "I think all the staff must be well trained, they all know what they are doing and nothing seems to phase them", "The girls who come are brilliant, they do such a great job I'd be lost without them", "All the carers do a good job" and "The support I get is excellent."

Relatives told us, "The ones [care staff] who come to help mum are brilliant, she looks forward to seeing them, they do her meals and help her get ready so she really values them", "All the staff seem knowledgeable, they go about their business without any fuss", "We have seen a change, we see the same ones [staff] so they get to know mum and what she needs. When they know how she likes things they can do a better job" and "They are very, very good; we have no complaints about the standard of staff."

At our comprehensive inspection in June and July 2016, we found the service had registered provider had failed to ensure the service could deploy suitable numbers of suitably qualified, competent, skilled and experienced staff to deliver care and support to the people who used the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 18 described above. This meant that the service was compliant with Regulation 18.

At our comprehensive inspection in June and July 2016, the registered manager and the care delivery director informed us that they became aware in March 2016 that records had been falsified within the service. The falsified records included staff training and supervision dates; the falsification of records enabled staff who did not have up to date training and who had not received appropriate amounts of supervision and mentorship to be allocated care calls [the registered provider's IT systems prevented staff who did not have up to date training and who had not received appropriate amounts of supervision being allocated care calls]. At the time of our comprehensive inspection in June and July 2016, no action had been taken to prevent staff who did not have up to date skills and knowledge or had not received effective supervision and professional development from delivering care and support to people.

During this inspection we saw evidence to confirm all staff had completed relevant training to equip them with the skills and abilities to meet the needs of the people who used the service. This was including but not limited to, safeguarding vulnerable adults, The Mental Capacity Act 2005, moving and transferring people, medication, infection control, food preparation and first aid.

The care delivery trainer told us, "Allied have a learning and development programme; they have created all the training sessions based on best practice guidance, the trainers deliver the sessions to the staff." The registered manager commented, "We are introducing some on-line training but have face to face as well depending on the subject."

Records showed all staff had received a one to one supervision meeting in the last three months where people's care needs, staff training requirements, personal issues and anything else affecting their work was discussed. A member of staff told us, "I can't tell you how much things have changed. We have supervisions every couple of months and if I have any issues I can ring the office and they will get it sorted. We seem to be one big team now and let's just say we didn't used to be." This helped to ensure staff were supported in their role and enabled to deliver effective care to the people who used the service.

At our comprehensive inspection on in June and July 2016, we found the registered provider had failed to ensure the principles of the Mental Capacity Act (2005) were followed and that consent had not been appropriately gained for the care and support staff delivered. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 11 described above. This meant that the service was compliant with Regulation 11.

At our comprehensive inspection in June and July 2016, we found consent to care and support was not recorded appropriately. For example, one person's care plan stated they had vascular dementia and were forgetful; their care plan had been signed by their friend who was defined on the care plan as their representative. When their care needs were reviewed in July 2016 the care plan stated they had vascular dementia and were forgetful but they had signed to provide consent to the care and support that was to be provided. This meant that either consent had been provided in 2014 by a person who did not have the authority to do so or in 2016 the care plan was signed by a person who lacked capacity.

Another person's care plan had been signed in June 2015 by their sister who was defined on the care plan as their representative. Their new care plan produced in July 2016, stated the person had no impairment or disturbance of their brain and had been signed by the person to confirm their agreement with their new plan of care. There were no records to show that the person's sister had legal authority [power of attorney] to provide consent and agreement to the care plan in 2015 and included no reason why the person who had no impairment or disturbance of their brain had not signed the care plan themselves.

During this inspection we reviewed 10 people's care plans and saw that consent had been gained and recorded appropriately. We found no contradictory information such as the examples found at the comprehensive inspection in June and July 2016 and noted that the issues had been rectified. The registered manager told us, "We had so much to do [160 care plans required reviewing and updating] in such a short space of time that some things were rushed and not done as well as we would have liked. We are still improving but mistakes like that will not be made again."

We spoke with staff who understood the principles of the Mental Capacity Act 2005 (MCA) and described the different ways that they could gain consent from people. The care deliver trainer confirmed that all staff completed a half day of MCA training and records we saw confirmed this. The field care supervisor said, "I do people's reviews and have to assess their capacity; I can tell quite quickly if they don't. I will always make sure I speak with the social worker and people's families so we can get consent for the care they need." A member of care staff told us, "We have done early warning signs training [recognising deterioration in a person's health and general well-being]. If I think someone has the onset of dementia or is confused I would report it straight away."

Is the service caring?

Our findings

People told us they were supported by caring staff who knew their needs and understood their preferences for how care and support was to be delivered. One person said, "They are very caring, I've known some for years and I really do depend on them." A second person told us, "The staff who support me are heaven sent; they arrive every day with a smile of their faces and do all sorts of things for me." Other people commented, "I know it's not a friendship but I do rely on the girls who come, I couldn't live alone without their help" and "My carers are truly caring and kind people, they really are."

People confirmed staff treated them with dignity, respect, supported them to be independent and delivered care that met their individual needs. One person said, "I was worried about getting people in but the staff have been great, they haven't taken over, they do the things I can't and help me to continue to do the things I still can." Another person told us, "They treat me with respect; they talk to me as an equal and always ask if there is anything I would like doing." Other people commented, "I couldn't live alone without their help and that's a simple fact of life and getting older", "They are polite considerate and patient, what more could I ask for?" A relative said, "They support my son to shower, shave, get dressed, everything. He feels more independent because his parents aren't doing everything for him."

At our comprehensive inspection in June and July 2016, it was evident people's care plans were not up to date and did not reflect people's care and support needs. People did not receive person centred care, staff left care calls early and arrived at care calls earlier or later than had been agreed which meant people's preferences for how care and support was to be delivered were not being met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the service was compliant with Regulation 9.

At our comprehensive inspection in June and July 2016, 160 people's care plans were out of date and required reviewing. Some people's care plans had not been reviewed or updated since their creation in 2013 and 2014. We cross-referenced people's out of date care plans with their most recent log books [records of the care staff have delivered] which, provided clear evidence that staff were delivering care and support that had not been planned for.

During this inspection we saw evidence to confirm people's care needs had been reviewed and their care plans had been updated to reflect the support they required. We reviewed 10 care plans and cross referenced the log books which enabled us to verify that staff delivered planned care in line with people's preferences. We saw that a singular sheet had been created that contained all of the care people required at each care call to enable staff to deliver care in a person centred way. A member of staff told us, "There is one sheet for every call and it tells us exactly what needs doing, which means nothing gets missed and we know how to do things the way they [the people who used the service] like it doing."

At our comprehensive inspection in June and July 2016, staff told us they were not always able to get to know the people they supported or build relationships with them. We were told, "I get swapped around a lot and I do a lot of covering so I don't always know the people I am going to see."

During this inspection the registered manager told us that the service used to have over 1000 hours of unallocated care calls each week which meant people who used the service were not supported by regular care staff and care calls had to be allocated [to care staff] on a week by week basis. The care delivery director told us the service had developed 'core care teams' for each person, which meant they were supported by the same group of staff consistently. A member of staff commented, "My rota is planned now, I know where I am going, who I am seeing; it's so much better this way, it's easier for me and better for the clients because we all get to know each other and you build a relationship."

At our comprehensive inspection in June and July 2016, we saw call monitoring information that showed staff left care calls early and arrived at care calls earlier or later than had been agreed. A member of staff told us, "I leave all my calls early, sometimes it's a few minutes but at the busy times of day I will leave 15 minutes early."

During this inspection we saw records to show staff rarely left care calls early. The registered manager told us, "It is something we have monitored closely, when we have reviewed the logs we have identified which staff were doing it [leaving care calls early] and called them into the office to discuss why." Records showed that of the week of this inspection the service had less than a 6% deficit between commissioned and delivered hours, the service was commissioned to deliver 1530 hours and actually delivered 1451 hours.

Call monitoring records showed staff continued to arrive earlier or later than agreed to deliver care in some instances. We found example where staff arrived up to an hour and a half early to deliver evening care. One person's care plan stated 'sleeps very well after taking my night time medication', staff arriving earlier than agreed could affect the person's evening routine and sleeping patterns. Records showed staff were, on occasion, over an hour later to morning care calls where people required support with personal care and dressing; staff arriving late meant people would have to wait which could have an adverse effect on their daily routine. The registered manager and care delivery director told us they were unaware that staff had failed to arrive at agreed times but would ensure that the issue was addressed. The registered manager said, "It's an oversight, we have focused on making sure staff stayed for the full duration of the call we have not looked at when they were arriving. I assure you I will make sure it stops."

We spoke with the people who did not receive their call at the planned time and they told us that they did not have an issue with the time staff arrived; as long as it was the same every day, which it was.

Is the service responsive?

Our findings

People who used the service and their relatives confirmed they were involved with the initial and on-going planning of their care. One person told us, "I have just had a review; I had a long chat with a lady from the office and answered all of her questions." A second person said, "If I am completely honest I don't know what is in my care plan but I do know it must be better than it used to be, the girls read it when they come and then they know what needs doing. They used to have to ask me all the time which did get annoying." A relative commented, "I attended [my relative's] review. [My relative] answered all the questions and I was just there to add any bits that got missed, I do have to say things have got a lot better recently, we are very happy."

At our comprehensive inspection on in June and July 2016, we found the registered provider had failed to ensure the service delivered safe care and treatment because a high number of care plans had not been reviewed since they were created in 2013 and 2014, and some information in them was out of date. This meant the registered provider held very limited information about people's current needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 12 described above. This meant that the service was compliant with Regulation 12.

At this inspection we saw evidence to confirm all of the out of date care plans had been reviewed and updated to ensure they reflected the care and support people required. We saw that log books were reviewed at regular intervals to ensure any changes in people's needs were identified and a review of their support needs could take place. The care delivery director told us, "So much effort has gone in at the service, we will never let those things [care plans not being reviewed and log books not being audited] happen again."

A member of staff told us, "We used to just get on with things, if people's needs had changed we just gave the care they needed because there was no point telling the office. I would just ring them now and I know they would do a review, they are so much better than they used to be."

At our comprehensive inspection in June and July 2016, we found the registered provider had failed to investigate and respond to complaints received within the service. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 16 described above. This meant that the service was compliant with Regulation 16.

At our comprehensive inspection in June and July 2016, we found the last internal audit of the service was completed in October 2015. The audit showed the service had only achieved 59% compliance regarding the

complaints process. The audit highlighted that responses failed to cover all aspects of the complaint, provide information to the complainant to enable them to escalate their complaint if they were unsatisfied with the initial response, communicate the learning achieved and create an action plan to ensure improvements were made within the service. We reviewed the complaints received by the service and found they were not used to drive quality and improvement across the service. For example, numerous people had complained that staff failed to stay for the full duration of the care call; despite this no action had been taken to address the issue.

At this inspection we reviewed all of the complaints received by the service since our last inspection, we saw that each complaint was logged on to an internal IT system and was tracked by the registered manager and care delivery director to ensure it was processed in line with the registered provider's complaints policy.

When a complaint was received a response letter was sent to the complainant outlining the investigation and response timescales. If the response was delayed for any reason the complainant was informed why this had occurred and this was also recorded on the internal IT system. The registered manager explained, "We have 28 days to investigate complaints and the directors can see when they have gone over and we have to provide a reason why." The care delivery director said, "I see all the complaints and the response before it is sent out, I make sure all the issues are covered and that we share any lessons learned across my patch."

People we spoke with confirmed they knew how to complain. One person said, "This may sound strange but I would complain now, I have complained in the past and nothing was done but I have confidence that they would sort out things out now." Other people said, "I would ring the office if I wanted to complain", "I would speak to the manager" and "I have complained in the past and things got sorted out, it took a while but it was sorted and that's the main thing."

Is the service well-led?

Our findings

A person who used the service said, "Things have really changed in the last six months, when you ring the office they are on the ball. When I used to ring up they would just say they would call you back then never bothered." Another person commented, "It all seems more organised now, I have the same few carers coming and I have just had a review to make sure everything was doing ok. I'm happy."

A member of staff told us, "I am so much more confident in the company; the office staff have put so much work in to sort things out and I think we are better now than we have ever been." Another member of staff said, "It's a better place to work, we can ring the office or pop in and they are so much nicer, it's calmer in there [the office] and if we ring up with an issue they help us instead of just fobbing us off." The registered manager added, "Some of the girls came in and decorated the office [put up Christmas decorations and a tree], that might not seem like much but I saw that as an indication that they were happier at work. They certainly wouldn't have done it six months ago."

At our comprehensive inspection in June and July 2016, we found the registered provider's governance and quality assurance arrangements were inadequate and failed to ensure people received safe, effective high quality care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had made satisfactory improvements in relation to the requirements of Regulation 17 described above. This meant that the service was compliant with Regulation 17.

At our comprehensive inspection in June and July 2016, it was evident that effective systems had not been implemented to ensure staff were trained appropriately or had the skills and knowledge to meet the assessed needs of the people who used the service. Records showed staff were not trained in line with the registered provider's requirements and had not received suitable amounts of supervision and one to one support. Spot checks had not been completed on all staff to ensure they delivered the care and support people required safely and effectively.

During this inspection we saw that staff had received training, supervision and support as required. All training and supervision records were stored on the registered provider's internal IT system; when a member of staff required refresher training or a supervision, which was on a three monthly basis, an automated alert was sent to the care delivery manager. The care delivery manager then allocated the supervision to a care co-ordinator who ensured the person received the support they required.

The care delivery trainer told us, "When someone needs refresher training the office [care delivery manager] inputs that into the system and I get an alert message to come and deliver training." They went on to say, "I cover the local area so there isn't ever a long wait for training."

At our comprehensive inspection in June and July 2016 we saw that the service was rated at 26%

compliance through the registered provider's internal monitoring systems. This was due to 175 log books and 99 medication administration records (MARs) required auditing. In addition, care plans for 160 people were out of date.

At this inspection we saw that every person who used the service had an up to date care plan, which meant it had been reviewed within the last 12 months and all log books and MARs had been audited in the last three months. The registered provider's IT system sent alerts to the care delivery manager when reviews and audits required undertaking. The service delivery manager then allocated work to the field care supervisor to ensure it was completed in the necessary timescales.

The service delivery manager told us, "The system [the registered provider's internal IT system] works really well, to be fair it always has, it's only when someone knowingly by-passes it and inputs things that haven't happened that there is a problem." The care delivery director said, "If any care plans become out of date the regional director gets a report and immediately wants to know why, it can be for a genuine reason like the person is in hospital but the service have to produce an action plan, which gets monitored at a high level." This helped to ensure that the senior management were aware of and shared responsibility for the day to day management of the service.

At our comprehensive inspection in June and July 2016, we were informed that the registered provider had disbanded its internal audit team in October 2015. The registered manager commented, "It was a huge mistake in my opinion." The care delivery director told us, "When the team was disbanded, so were the audits. We only moved to the self-audit system in May [2016] so the last audits that were done in this service were in October 2015."

During this inspection we saw that the service relied on the registered provider's IT systems to ensure reviews, audits, staff training and mentorship were completed when required. The self-audit tool that commenced in May 2016 was also used; the tool required two care files, two staff files and one complaint to be audited each month in each of the registered provider's services. We raised concerns with the registered manager and the care delivery director that the sample size was too small to gain an accurate representation of the quality of information produced in the service and could not be used to drive consistency and quality. The care delivery director told us, "Lots needs to be added to the current audit tool, it's not wide enough in its scope. I have created action plans on the back of the work we have done in the service and it will improve." They added, "We still have a long way to go but we know how to get there and will keep pushing until we get to where we want to be."

When concerns were raised through internal audits action was taken to improve the service where possible. For example, the service delivery manager told us, "Through our audits we found some of the appraisals or supervisions were not done to our usual standard. They have been done but not to a very high standard so we will redo them." The registered manager added, "We will speak to the staff involved and ask them if they want to come in for an additional appraisal and let them decide [if they want a second appraisal]."

At our comprehensive inspection in June and July 2016, we found the registered provider had failed to ensure notifiable incidents that occurred within the service were reported to the CQC as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

During this inspection we reviewed the accidents and incidents records held within the service. We cross referenced the information with the notifications we had received, which provided assurance that we had been informed of all of the notifiable incidents that occurred. This meant that the service was compliant

with Regulation 18 (of the Care Quality Commission (Registration) Regulations 2009).