Capital Homecare (UK) Limited

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Inspection report

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05 October 2016
06 October 2016
07 October 2016
14 October 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 05, 06, 07 and 14 October 2016 and was announced. Capital Homecare (UK) Limited is a domiciliary care provider located in the Royal Borough of Greenwich providing care and support to approximately 400 people across a number of London Boroughs. There was a registered manager in post at the time of our 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.

We have inspected the service twice previously in 2016: in February 2016 and June 2016. We found breaches of legal requirements at both of these inspections, and people were placed at risk of unsafe and poor quality care. Medicines were not safely managed, risks to people had not always been adequately assessed and the provider did not have effective systems in place to monitor and manage areas of risk. Records were not always accurate and could not be promptly located. The provider did not have an effective system in place to monitor staff training needs, and the provider's recruitment practices did not meet the requirements of the regulations. Notifications had not always been made. Our concerns were so significant following the February 2016 inspection that we also imposed a condition on the provider's registration, restricting them from taking on any new service users without prior agreement from the Commission. We also wrote to the provider asking them to take action to improve their recruitment practices and this action has been completed.

Following the June 2016 inspection we also took urgent enforcement action, placing a condition on the provider's registration, requiring them to submit medicines audits and any actions taken as a result of audit findings to CQC on a regular basis.

At this inspection on 05, 06, 07 and 14 October 2016 we found that the provider had made improvements in some areas. However, we also identified continued breaches of regulations because people's medicines were not managed safely. Records relating to people's medicines administration were not always accurate or reflective of the medicines they had been prescribed. Audits of people's medicines were not always effective in identifying and addressing issues. Risks to people had not always been adequately assessed and there was not always guidance in place for staff on how to manage risks to people safely. Some records were not always accurate or had not been properly completed. The provider had made improvements to the systems used to monitor and mitigate risks to people and we saw examples where this had driven improvements in people's support planning. However, reviews of people's care records had not always been prioritised safely and had not always addressed deficiencies in recorded information, placing people at risk.

We also identified breaches of regulations because the provider had not always obtained consent from people or their representatives in line with the requirements of the Mental Capacity Act 2005 (MCA), and because the provider did not have an effective system in place for consistently recording and responding to complaints.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There were sufficient staff deployed within the service to safely meet people's needs. The provider had appropriate recruitment processes in place but improvement was required to ensure that references received on behalf of new staff were consistently from robust sources. People were protected from the risk of abuse because staff were aware of the types of abuse that could occur and the action to take if they suspected abuse.

Staff were supported in their roles through training and regular supervision. They were aware of the importance of seeking consent from people when offering them support. People were supported to access healthcare services when required and were supported by staff to maintain a balanced diet where this was part of their assessed needs.

Staff treated people with kindness and consideration, and people told us their privacy and dignity were respected. People were involved in day to day decisions about their care and treatment, and received person centred care which met their individual needs. The provider had a complaints procedure in place and people told us they knew how to raise concerns.

The provider had systems in place to monitor the quality of the service provided and people told us they thought the service was well managed. Staff were aware of the responsibilities of their roles and told us the service was focused on providing good quality care to people.

The overall rating for this service is 'Requires improvement'. However, the service will remain 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.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's Medication Administration Records (MAR) did not always contain accurate information about the medicines people had been supported with or prescribed. Risks relating to the administration of people's medicines had not always been properly considered. Medicines audits were not effective in identifying issues.

Risks to people had not always been identified and there was not always clear guidance in place for staff on how to manage risks.

There were sufficient staff deployed to meet people's needs. The provider undertook checks on new staff before they started work. However improvement was required to ensure references were sought from appropriate sources.

People were protected from the risk of abuse. Staff were aware of the types of abuse that could occur and knew to report any concerns they had appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought consent from people when offering support. However, consent had not always been obtained in line with the requirements of the Mental Capacity Act 2005 (MCA) where required.

Staff were supported in their roles through training, supervision and an annual appraisal of their performance.

People were supported to maintain a balanced diet.

People were supported to maintain good health and had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with kindness and consideration by staff who were familiar with their needs.

People were treated with dignity and their privacy was respected.

People were involved in making decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always accurate and did not always reflect the support they required.

People received support which met their individual needs and preferences. People were supported to maintain their independence.

People were aware of how to complain and expressed confidence that any concerns they raised would be addressed. However, the provider did not have an accurate record of all of the complaints raised against the service and some complaints had not been responded to within the timescales set out in the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to people's care planning and risk assessments through the provider's system of reviews. However, reviews had not always been prioritised appropriately to ensure people at greatest risk were assessed promptly. Care plan reviews had not always identified the issues we found during this inspection, placing people at risk.

Action had not always been taken in response to findings from external monitoring bodies.

The provider had systems in place to seek feedback from people receiving services. However, records of feedback were not always an accurate reflection of people's views about the service.

People and staff told us they felt the service was well managed. Staff were aware of their roles and responsibilities, and who they should report any concerns to.

Capital Homecare (UK) Limited

Detailed findings

Background to this inspection

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

This inspection took place on 05, 06, 07 and 14 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure the registered manager was available.

The inspection team consisted of two inspectors on the first and second days, an inspector on the third day and an inspector and a pharmacist inspector on the final day. An expert by experience also conducted telephone calls to seek feedback from people using the service and their relatives during the second day of the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the provider, including the provider's information return (PIR). This is a form submitted by the provider giving data and information about the service. We also looked at statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also sought and received feedback about the service from six local authorities who commissioned services from the provider. We used this information to help inform our inspection planning.

During the inspection we spoke with 12 people, nine relatives, 14 staff, the registered manager and the nominated individual. We also visited a further five people in their homes to gain feedback on their views and experiences of receiving services from the provider. We looked at records, including 25 people's care records, the recruitment records of six staff employed in 2016, staff training and supervision records, and

other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection on 17 and 19 February 2016, and our last focused inspection on 23 June 2016 we found breaches of regulations because people's medicines were not safely managed. Records relating to the support people required with their medicines lacked sufficient detail and in some examples contained contradictory information about the type or frequency of support that was required. Following our inspection on 23 June 2016 we took urgent enforcement action and imposed conditions on the provider's registration, requiring them to send us information on a monthly basis to demonstrate that the service was monitoring, and acting to address, any identified risks to people with regards to the management of their medicines.

At this inspection on 05, 06, 07 and 14 October 2016 we found that whilst the provider had taken action to improve the safety of the management of people's medicines, there were still continued serious concerns regarding medicines management by the service which placed people at risk of unsafe support. People's Medication Administration Records (MAR) did not always include accurate information about the medicines they were supported with. For example, we visited one person in their home and found that some of the medicines they had been prescribed were not included on their MAR. This meant we could not be assured that the person in question had received the correct support with their prescribed medicines.

We also noted that a dose of one medicine had been incorrectly signed by staff to confirm it had been taken at lunchtime on the day of our visit, although the lunchtime call had not at that time been made. This meant the person's MAR did not accurately reflect the medicines they had taken, placing them at risk of unsafe support.

People's care plans contained information about the medicines they had been prescribed but this information did not always accurately reflect the information on their MAR. For example, one person's care plan contained a record of seven medicines they had been prescribed but their MAR contained details of 14 medicines. In another example we saw medicines listed in people's care plans which were not recorded on their MAR. We were therefore unable to determine whether people had correctly received all of their current medicines as prescribed.

Potential risks in the way in which people took their medicines had not always been identified in their care plans and risk assessments to demonstrate they had been properly considered when ensuring people's safety. For example, we visited one person during our inspection and spoke to the staff member that supported them who explained they needed to crush the person's medicines before administering them as they had difficulty swallowing. There was no information regarding the need to crush medicines in the person's care plan or risk assessment, or any evidence to indicate that this had been considered or discussed with healthcare professionals to ensure it was safe to do so. This placed the person at risk of unsafe medicines administration.

In another example we found that one person's care plan stated that they took a medicine four times each day which required a minimum four hour gap between each dose. Staff were required to provide support

with the person's medicines during morning and bed time visits which their care plan identified as being the first and last doses of the day. However, on review of staff timesheets, we saw that the timing of the visits did not allow for the person to self-administer their medicines twice between those visits whilst ensuring a four hour gap was maintained, placing them at risk.

Medicines audits conducted at the service were not effective. The provider had undertaken monthly medicines audits to ensure medicines were safely managed. However, these audits had not been effective in identifying the issues we found at this inspection. We spoke to the registered manager about this and they confirmed that the current medicines audit process used by the service was not robust enough to identify changes to people's prescribed medicines and that they could not therefore be assured that records relating to the support people required with medicines were consistently up to date and accurate.

These issues were a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our previous comprehensive inspection on 17 and 19 February 2016 we found breaches of regulations because risks to people had not always been assessed placing them at risk of unsafe care. We also found that where risks had been assessed there was not always sufficient guidance in place for staff on how to manage risks safely. Following the inspection, we took enforcement action, imposing a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

We followed these concerns up during our 23 June 2016 inspection and found that whilst some improvements had been made to the way in which risks to people had been assessed, they had not been rolled out across the whole service. Therefore sufficient action had not been taken to ensure people using the service were safe.

At this inspection on 05, 06, 07 and 14 October 2016 we found that the provider had continued to make some improvements in assessing risks to people. However, we also identified ongoing serious concerns because risks to people had not always been assessed and it was not always clear that identified risks to people had been fully considered to ensure they were managed safely.

We reviewed the care records for one person and found that there was no risk assessment in place despite assessment paperwork from the commissioning local authority identifying a number of significant health and environmental risks to the person. There was no guidance in place for staff on how these risks should be safely managed, placing the person at risk of unsafe care and treatment. We brought this to the attention of the registered manager, who arranged for a risk assessment to be conducted during the week during our inspection.

In another example we found guidance in the home of two people receiving services from the provider on how to fortify meals to reduce the risks associated with malnutrition. The guidance was not named or dated and there was no information in the two people's care plans regarding the need to fortify either of their meals. Staff we spoke with were not aware of whether the guidance needed to be followed, or for which person it applied to. This meant there was a risk that one of the two people receiving services was not receiving adequate support to manage the risk of malnutrition. The registered manager contacted the commissioning local authority to follow up this concern during our inspection, although we were unable to check on the outcome of their enquiries at that time.

Where areas of risk had been identified, there was not always sufficient guidance for staff on how they

should be managed or to demonstrate the risks had been fully considered. For example, where staff had identified that people used bed rails as part of their risk assessment process, there was not always evidence to demonstrate that risks associated with the use of such equipment had been assessed. In another example, where people required support around moving and handling, we noted examples of assessments referring for the need to use "correct moving and handling techniques" without providing any information about the techniques to be used. We also saw examples of assessments which had identified people as having conditions such as diabetes but which contained little or no information on how these conditions should be managed safely.

These issues were a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We spoke to senior staff and the registered manager about the lack of guidance for staff on how to manage risks and they confirmed that they were aware that these areas needed addressing. They told us that they were in the process of updating people's assessments accordingly and showed us examples of assessments which included detailed moving and handling information, bed rail assessments which included consideration of the risks associated with their use and information on how to manage medical conditions safely. The provider also updated some people's risk assessments to include this information where relevant during the time of our inspection and we will check on this at our next inspection.

At our previous comprehensive inspection on 17 and 19 February 2016 we found a breach of regulations because the provider was unable to demonstrate that they had considered gaps in staff members' employment histories as part of their recruitment process. Following the inspection the provider wrote to us and told us the action they would take to address this concern.

At this inspection on 05, 06, 07 and 14 October 2016 we found the provider had addressed this issue and had complied with the requirements of the regulation. However, further improvement was required to the process used to ensure staff were of good character when they applied to work for the service.

Staff files showed that the provider undertook pre-employment checks on new staff before they started work at the service and contained completed application forms, checks on identification, criminal records checks and checks on staff member's right to work in the UK. However, improvement was required because whilst all of the files we reviewed contained at least one professional reference, we saw examples of second references having been provided by inappropriate sources, such as friends. We spoke to the provider about this and they told us they would ensure that where staff were unable to provide two professional references in future they would request references from more appropriate sources, for example, community leaders of higher education authorities. However, we were unable to check on the effectiveness of this at the time of our inspection.

People and relatives we spoke with told us there were sufficient staff deployed by the service to safely meet their needs. All of the people we spoke with confirmed that the right number of staff attended their calls each day. One person said, "I have never had a 'missed call' and someone has always visited. If my regular carers are off or sick they try to send me others carers that know me." Another person told us, "My carers are very good and always come on time. If they don't come they always send me someone else. I have never had a time when no one has come."

Staff we spoke with confirmed they were able to undertake their assigned visits without having to rush between calls. Office staff explained that most care staff only had one of two service users each who they were assigned to permanently to ensure people received a consistent service. They confirmed that because of this they were able to cover any unexpected staff absence at short notice without any problems. People

we spoke with also confirmed this to be the case.

People we spoke with told us they felt secure being supported by staff. One person said, "I think they [staff] are very good; I've no troubles." Another person told us, "I do feel safe with the carers and they know how to use my equipment." A relative we spoke with commented, "Yes, I think they do things safely." However, another relative told us they felt staff could be more gentle in the support they offered their loved one. We spoke to the registered manager about this and he confirmed he would arrange for a spot check of the staff in question, although we were unable to check on the outcome of this at the time of our inspection.

Records showed that staff had received training in safeguarding adults which was refreshed on a regular basis. Staff we spoke with were aware of the different potential types of abuse that could occur and the action to take if they suspected abuse. Staff were also aware to escalate concerns if they felt it necessary to do so, in line with the provider's whistle blowing procedure. One staff member told us, "I know what to do [if they suspected abuse] and if the manager didn't act I'd whistle blow and contact the local authority straightaway."

There were arrangements to deal with emergencies. Records showed that staff had received first aid and relevant health and safety training and knew the action to take in the event of an emergency. Two people commented that it was not always easy to get in touch with someone at the office when they called, although all of the other people we spoke with were more positive. One person told us, "If you have an accident they [staff] will come straight out." Another person said, "I know who to call if I have problems, the office staff have always been available when needed."

Requires Improvement

Is the service effective?

Our findings

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.

At our previous comprehensive inspection on 17 and 19 February 2016 we found improvement was required because senior staff were not aware that there may be situations in which they or their staff may be responsible for undertaking an assessment of a person's capacity to make specific decisions, although at the time of our inspection they told us that all of the people receiving support from the service had capacity to make decisions for themselves.

At this inspection on 05, 06, 07 and 14 October 2016 we found that some people's risk assessments contained mental capacity assessments which made reference to people's capacity in general terms rather than with regard to a specific decision making area. We noted that two people had been assessed as lacking capacity without identifying the decision the assessment related to, and that there was no record of any type of best interests decisions having been made. Proper steps had not been taken to obtain consent to provide care and support for the two people in question, in line with the requirements of the MCA.

This issue was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Staff we spoke with were aware of the importance of seeking consent when supporting people. One staff member said, "'I explain what I'm there for, why I'm doing it and ask if they're happy, or if any more assistance is needed." Another staff member told us, "I also ask people about the support they want and would respect their wishes. I can try to encourage them but can't force them to do anything." People also confirmed staff sought their consent when offering support. One person told us, "[Staff] ask me, "Is it alright if I do this or that?"." Another person said, "They [staff] check that I'm happy with what they're doing."

People told us they thought staff were competent in the performance of their duties. One person said. "They [staff] know what they're doing." Another person told us, "I think staff are well trained." A third person commented, "They're very good and very efficient."

Staff told us, and records confirmed, that they had received an induction when starting work at the service and training in a range of areas, including moving and handling, first aid, health and safety, safeguarding and infection control. One staff member told us, "I've had plenty of training; it's been really useful. I feel competent to do my job." The provider confirmed that staff received regular refresher training in the areas they considered to be mandatory. Records showed that most staff were up to date with their training and that there were plans in place for staff to attend relevant courses where refresher training was due.

Records showed that staff were supported in their roles through regular supervision and an annual appraisal of their performance. Supervision sessions included both one to one and group sessions and staff told us that these sessions enabled them to discuss any issues they had. One staff member said, "Yes, I feel supported; I can talk to my manager about my problems. I'm a carer and a parent so I need to discuss things like the times of my calls with them."

People were supported to eat and drink appropriately where this had been identified as part of their care plan. One person told us, "The carers cook whatever I want to eat, they are very good." A relative we spoke with commented, ""There is always a hot meal prepared for [their loved one], and always a cup of tea." People's care plans identified the level of support people required with their meals and where support was required, information about any known food allergies people had in order to ensure they were not supported to eat unsafely. Staff we spoke with were aware of the level of support people required, as well as their food preferences. They were also aware of the importance of ensuring people were adequately hydrated and people we spoke with confirmed that staff gave them drinks, even if they didn't require support at meal times.

People were supported to maintain good health and had access to healthcare professionals when they required them. Staff we spoke with confirmed that they would assist people to receive support from healthcare professionals if required, for example by calling their GP if they were unwell or contacting senior staff to arrange a review of their needs if their health declined. People told us that they were usually able to access healthcare services independently but one relative confirmed staff had supported their loved one to call their GP and then an ambulance when they were unwell, before contacting them to inform them of the situation.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us staff acted with kindness and consideration. One person said, "They [staff] are kind and thoughtful." Another person told us, "The staff are very caring; they'll do anything I need." A relative commented, "They make [their loved one] feel at ease. They know him and how to relax him."

Senior staff explained that they ensured people received consistent support by assigning care staff to fixed rotas with minimal changes from week to week. They explained that this allowed staff to build strong relationships with the people they supported. People we spoke with confirmed that they received support from regular care staff and that this was something that was important to them. One person described their relationship with a staff member, saying, "I feel we are like sisters." A relative told us "[Their regular care worker] has become like one of the family." Another relative commented, "[Their loved one] had got used to the carers he has. They know him and he knows them."

People were treated with dignity and respect. One person told us, "Staff listen to you and are helpful." Another person said that staff were, "Very pleasant; they respect you." Staff told us how they worked to ensure people's privacy was respected, for example by ensuring doors and curtains were shut when supporting people with personal care. This was confirmed by people and relatives we spoke with. For example one relative told us, "When changing they make sure no one is in the room. If family are here they ask us to leave the room." A person also commented, "When they give me a bed bath, they cover me up."

People were involved in day to day decisions about their care and treatment. One person we visited explained that whilst they had a regular routine, staff worked flexibly to meet their needs each day. "Staff will do whatever I ask." Another person told us, "Sometimes [their care worker] will come back later if I need some sleep." A third person commented that staff were happy to do any extra little tasks they needed support with each day, in addition to the regular support they required, and that they guided staff on the support they wanted to receive each day.

Records showed that people had been consulted about their care needs when they started using the service and during annual reviews. Whilst some people could not always remember receiving information about the service, we saw service user guides in the homes of people we visited which included details about who they contact if they wanted to request service changes, information about key policies and procedures and guidance on how they could raise a complaint.

The provider explained that they worked to ensure staff were suitably matched to people wherever possible in order to support their needs with regards to their disability, race, religion, sexual orientation and gender. We received positive comments from people about the support they received in these areas, although one relative raised concerns about staff not being able to speak the languages their loved one spoke, which created some issues with the support they received. The registered manager told us they were seeking to recruit staff who could be appropriately matched to the person in question but they had not been successful to date so had been unable to do so at that point. We noted other examples where people had been

matched to staff who spoke their language and one person we spoke with commented positively about this. Staff we spoke with were aware of the specific cultural needs of the people they supported and knew for example to prepare culturally appropriate meals for people where required, or wear culturally appropriate clothing.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection on 17 and 19 February 2016, and our last focused inspection on 23 June 2016 we found a breach of regulations because people's care plans were inaccurate and did not reflect the support they received. Following our inspection on 17 and 19 February 2016 we took enforcement action, imposing a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 05, 06, 07 and 14 October 2016 we found the provider had made improvements to detail and accuracy of the information in people's care plans. However, we found that some people's care plans were not always responsive to people's needs because they contained inaccuracies or omissions regarding the support people required. For example, we saw examples of care plans which did not accurately reflect the frequency at which people required support with their medicines.

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

People and relatives told us they knew how to raise a complaint if they had any concerns about the service. One person said, "I've never needed to complain about the service but know how to if I wanted." A relative told us, "I haven't had to (complain) because the carers are so good but I would feel confident to do so." However another relative commented that they had previously complained to the provider and whilst their complaint had been addressed, they felt that it took too long to resolve.

The provider had a complaints policy and procedure in place which described the process for handling and escalating any concerns received by the service, including the expected timescales for response. We reviewed a sample of complaints received during the previous six months and found that complaints had not always been responded to in line with the timescales in the provider's procedure.

We also received information from a commissioning local authority that they had raised 14 complaints with the agency in 2016. However, the provider only had a record of two of these on their complaints log when we reviewed this. This meant we were unable to determine whether the remaining complaints had been investigated and necessary action taken in response to any failure identified because the complaints system was not established and operated effectively.

These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Records showed that people's care plans had been developed based on information received by the service from the relevant commissioning local authority. They contained information about people's preferences in the way they received support and their preferred daily routines. Not all of the people we spoke with could recall whether their needs had been discussed with them prior to the service starting, although staff we spoke with told us that this was their standard practice. Records showed that care plans were reviewed on

at least an annual basis, or more frequently if people's needs changed.

People told us they received care and support which met their individual needs and preferences. One person said, "The staff know my routine; they know what I like to eat and how I like to get ready in the morning." Another person told us, "The carers help me with my personal care, cleaning and breakfast and they know exactly how I want things to be done." A staff member we spoke with confirmed, "I support people to keep to the routine they prefer whilst completing my duties."

People were supported to maintain their independence. Staff explained how they encouraged people to be involved in their own support and to do things for themselves wherever possible. People we spoke with confirmed that staff encouraged them to be independent. One person explained how they felt staff supported them in this area, for example by encouraging them to take part in activities such as going out on a recent outing.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on 17 and 19 February 2016, and our last focused inspection on 23 June 2016 we found a breach of regulations because quality assurance systems used by the provider were not always effective and did not always identify issues or drive improvements, and because records we requested could not always be promptly located or provided. Following our inspection on 17 and 19 February 2016 we took enforcement action, imposing a condition on the provider's registration, preventing them from taking on any new service users without prior agreement from the Commission.

At this inspection on 05, 06, 07 and 14 October 2016 we found the provider had made improvements to the storage of their records and that people's care files were available promptly when requested. We also found improvements had been made through the ongoing process of reviewing and updating people's care plans and risk assessments to ensure they were accurate and fit for purpose. For example, we noted that some reviewed care plans contained detailed information of the things staff should consider when supporting people with specific medical conditions which had not been in place previously.

Despite these improvements, we also noted that the reviews of care plans and risk assessments had not consistently identified some of the issues we found during this inspection. For example we found inconsistencies or inaccuracies in the information about the support people required with their medicines which placed people at risk of unsafe support. We also noted that the provider's process for prioritising reviews of people who were at highest risk had not always been effective as one person's file had not been reviewed despite significant risks to their health and wellbeing having been identified in their local authority assessment paperwork. We spoke to the registered manager about this and they told us the person should have been prioritised. They arranged for a review to be conducted during the week of our inspection although we were unable to check on the outcome of this because the relevant documentation had not been returned to the service.

We also found that some records relating to people's care had not always been completed properly. For example, some consent forms had not been signed by the person receiving support or their representatives to confirm their agreement to the care being provided, or had been signed by a representative of the person receiving support without identifying the reason why they had not been signed for by the individual themselves.

Telephone monitoring records showed that people were happy with the service they received and reflected positive outcomes in all areas. However, we noted that in one case a person had responded positively regarding a question relating to communication, despite the relative of the person telling us there were problems in this area when we spoke with them. This meant that the record of feedback from the person in question was not an accurate reflection of their or their representative's views of the service which prevent the provider from identifying the potential need for improvement in this area.

Whilst we received some positive feedback from local authority commissioners about improvements that had been made in response to issues they had identified at the service, we also found other examples where

the provider had not acted to address areas of concern reported to them by commissioners as part of their monitoring of the service. For example, we reviewed a report from a local authority commissioner following a visit they had conducted in August 2016 which identified specific issues in people's care planning. These concerns had not been addressed when we reviewed the care plans as part of our inspection. We spoke to senior staff about this and they put an action plan in place to address the issues, although we were unable to check on the outcome of all of the actions at the time of our inspection.

Senior staff explained they were in the process of adding all of their service users to an electronic call monitoring system so that they would be able to monitor service activity on a daily basis to ensure people were receiving their calls as planned. We saw examples of people having been added to the new system and noted that they had received the correct number of calls each day. However, where people were yet to be added to the new system, we were not always able to identify whether they had received all of their planned visits. For example, we found two visits to one person had not been signed for as completed by the staff member who provided their regular support. Office staff told us that these calls may have been covered by another member of staff. However, they were unable to provide timesheets or any other records to demonstrate this, so we could not be assured the calls had been made.

These issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At our last comprehensive inspection on 17 and 19 February 2016, and at our last focused inspection on 23 June 2016, we found a breach of regulations because the provider had not always submitted notifications relating to allegations of abuse as required. The Commission is still considering the appropriate regulatory response to resolve the problems we found in respect of this regulation.

At this inspection on 05, 06, 07 and 14 October 2016 we found that the provider had made notifications relating to allegations of abuse to the commission as required. The registered manager and senior staff confirmed they had made changes to their procedure for submitting notifications which had resulted in improvements in this area. Prior to the inspection the provider had also submitted a Performance Information Return (PIR) to the Commission which contained information about the service in order to help with the planning of the inspection. However, improvement was required because we found that the information in the PIR was not always accurate and did not correctly reflect the details we found during the inspection. The provider was able to provide more accurate information to the inspection team during the inspection process.

People told us they felt the service was well managed. One person said, "Personally I find them excellent; I can't fault them." Another person commented, "The service seems to be well managed and I like it very much." A third person commented, "I think the service is run very well; I have no complaints." These comments were reflective of the majority of the feedback we received but despite some people's positive experiences we found concerns around safety and quality of the service outlined in this report.

The provider sought feedback from people through home visits and telephone monitoring checks, and assessed staff performance during spot checks. Spot checks included an assessment of staff timeliness, communication and any use of equipment, for example the use of hoists when transferring people. Staff told us that they found spot checks to be helpful in identifying areas in which they could improve. For example, one staff member told us that additional training had been arranged for them following issues identified at a spot check.

The provider told us they were committed to making improvements to the service and to their

understanding of the management of adult social care services and we saw that they had recently gained a recognised qualification for management within health and social care. Staff told us that they thought the service was well managed and were aware of the responsibilities of their roles and who they reported to if they had any concerns or identified changes in people's needs. One staff member told us, "They [the management team] are really supportive; if a client needs something I can call my line manager and they'll sort it out." Another staff member said, "The management are supportive of staff. They are focused on providing good care to people using the service and expect us to be the same."

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 11 HSCA RA Regulations 2014 Need for consent Consent had not been obtained in line with the requirements of the Mental Capacity Act 2005, where required.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for recording and responding to complaints.