Aims Homecare Limited

Aims Homecare Limited - Leatherhead

Inspection report

59 Kingston Road
Leatherhead
Surrey
KT22 7SL

Tel: 01372386222
Website: www.aimshomecare.co.uk

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 30 July 2018 and was announced. The provider was given 24 hours' notice as we needed to be sure someone would be in the office during our inspection. This was the service's first inspection since it registered with us in May 2017.

Aims Homecare Limited – Leatherhead is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. At the time of our inspection 37 people were receiving support with personal care.

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

People were not always protected from avoidable harm and abuse as allegations of abuse had not always been escalated to the appropriate safeguarding authority. Risks to people had not been appropriately identified or addressed and the systems in place to support people with their medicines did not ensure this was managed safely. There were not enough staff and they were not deployed in a way that meant people's needs were met; they were given impossible schedules which affected punctuality. The provider responded to incidents appropriately but had not informed CQC as required by law. Staff were recruited in a way that ensured they were suitable to work with people in a care setting. People were protected by the prevention and control of infection.

People's needs were not assessed in a comprehensive or personalised way and care plans lacked detail about how staff should meet their needs. People gave us mixed feedback about the support they received with their meals, some people said the food was not good enough to eat. Staff received the training and support they needed to perform their roles. The service worked with other health and social care professionals to ensure people's needs were met. People were confident staff would support them to access healthcare services when they needed. The service was working in line with the requirements of the Mental Capacity Act 2005 but care plans lacked detail on how people expressed their choices.

People did not always feel that staff treated them with kindness and compassion. When people had established relationships with regular care workers their experiences improved and an emotional bond was established. The service did not consider the impact people's religious belief, sexual or gender identity may have on their experience of care. We have made a recommendation about supporting people who identify as lesbian, gay, bisexual or transgender. People were treated with dignity during care.

People's care was reviewed regularly but records did not always show they received personalised care that met their needs. People knew how to make complaints, and were confident things would change if they raised a concern. Complaints were investigated thoroughly by the provider. People were supported at the

end of their lives, but there was not clear information about what this meant within the care files. We have made a recommendation about supporting people at the end of their life.

There were not effective systems in place to monitor and improve the quality and safety of the service. The provider was not always following their own policies and there was limited oversight over the quality of records. The provider was starting to introduce new systems for quality assurance. There was a clear philosophy of care, and staff described their approach in a way that matched the provider's philosophy. People were asked for feedback about their experiences. People felt supported and valued by the registered manager and the provider recognised staff achievements.

We identified breaches of six regulations regarding person centre care, safe care and treatment, safeguarding service users from harm, staffing, good governance and notification of incidents. Full information about our regulatory response is added to reports when all appeals and representations have been completed.

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. Systems were not operating effectively to ensure people were protected from avoidable harm and abuse.

Risks faced by people had not been appropriately identified and plans in place to mitigate risk were unclear and insufficient.

Staff were not deployed effectively; they were given impossible schedules and frequently did not stay the full allocated time of visits.

People were supported to take medicines but systems did not ensure this was managed safely.

The provider had not told CQC about incidents as required by law.

People were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective. Assessments and care plans lacked detail and did not include details of how to support people in line with their preferences.

People gave us mixed feedback about the support they received with eating and drinking. Records did not always show people were supported to eat and drink enough to maintain a balanced diet.

The service sought consent in line with legislation and guidance, but care plans did not always include details of how people expressed their choices.

Staff received the training and support they needed to meet people's needs.

Staff worked with other professionals involved in people's care to

ensure they received the support they needed. People were confident staff would help them to access healthcare services when they needed.

Is the service caring?

Requires Improvement

The service was not always caring. People had mixed experiences of the attitude displayed by care workers.

The service did not always consider the impact people's religious beliefs had on their care preferences.

The service did not explore people's sexual or gender identity and the impact this may have on their experience of care.

People were supported to maintain their dignity while receiving care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not personalised and records did not always contain enough detail to show people's needs had been met.

People knew how to make complaints. Complaints were investigated thoroughly with appropriate actions taken to address concerns.

People were being supported at the end of their lives. Staff knew what support people needed, but this was not captured in their care files.

Is the service well-led?

Requires Improvement

The service was not always well-led. There were no clear systems for monitoring and improving the quality and safety of the service.

The provider was not always adhering to their own policies and procedures.

People were asked for their views on their experience of care.

Staff felt supported and valued by the registered manager.

The provider was in the process of introducing systems to strengthen the quality assurance systems.

Aims Homecare Limited - Leatherhead

Detailed findings

Background to this inspection

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

This inspection took place on 30 July 2018 and was announced. The provider was given 24 hours notice of the inspection as they provide a service to people in their own homes and we needed to be sure someone would be in the office. The inspection was completed by one inspector. This was the service's first inspection since it registered with us in May 2017.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five members of staff including the deputy manager, the coordinator and three care workers. After the inspection site visit we spoke with four people and two relatives. During the inspection we reviewed the care files of four people including assessments, care plans, and records of care. We reviewed four staff files including recruitment, supervision and training records. We also reviewed various other documents, records, policies and meeting records relevant to the management of the service. After the inspection we corresponded with the registered manager who sent us additional documents as requested.

Inadequate

Is the service safe?

Our findings

People gave us mixed feedback about how safe they felt using the service. One person said, "I don't always feel safe. Even my friends have noticed some of the girls' attitudes." A second person said, "I keep an eye on my things. I worry that things might go missing." However, another person said, "I feel very safe." A relative told us they were confident their family member was safe with staff and they were happy to leave their relative alone with care workers.

Staff told us they would report any concerns that people were being abused to the office. We reviewed records of incidents and investigations into allegations of abuse. The registered manager had completed safeguarding investigations into allegations of abuse which had been raised directly by people to the local authority. One investigation related to an allegation that a care worker had been sleeping on duty and neglected people. However, a similar allegation had been treated as a complaint and there was no record this had been raised as a safeguarding concern. This meant the provider had not consistently identified or reported incidents of potential abuse and had not always taken steps to ensure people were protected from abuse and avoidable harm.

The provider's safeguarding policy was comprehensive and included the steps that should be taken in response to an allegation of abuse. However, the sections of the policy about local contact details required to raise an alert had not been completed. This meant the information about how to raise concerns was not easily available within the policy. After the inspection the provider told us they updated their policy to include local contact information.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also reviewed incident forms and saw there had been an incident where an injury had occurred during the delivery of care. The person had required stitches. The incident report investigation stated that actions were for the care workers to ensure they reported incidents to the office. Staff meeting and supervision records showed lessons from investigation reports were shared with care workers to ensure incidents did not recur. Providers are required by law to notify the Care Quality Commission of any safeguarding concerns and certain injuries sustained during the receipt of care. The provider had not notified us of these two incidents. We discussed this with the registered manager who had not been fully aware of the need to submit these notifications.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and relatives told us they were confident staff knew how to support them to use their equipment in a safe way. A relative said, "They know how to use the hoist." Staff told us they were trained to use moving and handling equipment before working in people's homes. People's needs assessments contained a template for both environmental and mobility risk assessments. These had been poorly completed and did not include details of the risks people faced or the measures staff needed to take to mitigate the risks. For

example, one person's care file listed the equipment in place but the moving and handling assessment stated only they needed "two helpers" for all moving and handling manoeuvres and transfers. There was no information about what support these two staff should provide. The risk assessment section on the care plan contained information about this person's character, but the only information about risks and how to mitigate them stated, "[Person] has spent the last six weeks in hospital and now has no mobility – all transfers are to be used via rotunda [date]. Ensure [person] is wearing her safe call alarm." A rotunda is a piece of equipment that helps people to transfer.

Another person had no falls risk assessment or guidance for supporting them to mobilise safely despite a recent fall. The only information about risk management in their care plan stated, "[Person] is very independent. [Person] recently had a fall. [Person] had a stroke - it affected the left side. [Person] walks with a trolley." This is not sufficient information to ensure the risk of falls was mitigated. A third person's moving and handling risk assessment simply referred to "hoist" with no further guidance about how to support them to move in a safe way. This person had been prescribed a cream to reduce the risk of pressure wounds but there was no risk assessment in place regarding pressure care. The assessment template included a waterlow assessment. A waterlow assessment is a tool that can be used to calculate the risk that someone may develop pressure wounds. These had not been completed in any of the files viewed.

We explained our concerns about the level of detail in risk assessments to the deputy manager. They submitted updated care plans after the inspection. Although there was more detail about how to deliver care, the risk assessment remained insufficient. For example, regarding risk of pressure wounds the plan stated, "[Person] is prone to pressure sores due to being bed bound please keep an eye on this and report." The care plan instructed care workers to reposition the person four times a day using equipment, but did not say what position or how to make sure they were comfortable. There was no information about what skin changes would indicate a pressure wound was developing and should be reported. This meant people were at risk of harm as there was not enough information to inform care workers how to mitigate risks. After the inspection the provider told us guidance about pressure wounds was included in people's care files.

Information about the support people needed to take their medicines was not detailed enough to ensure medicines were managed safely. Care plans contained unclear information about the medicines people had been prescribed. For example, one person's care file contained a list of 11 medicine names with no dosage or timing information. There was no information about why the medicines had been prescribed or what side effects staff needed to be aware of.

We reviewed the medicines administration records (MAR) for two people and found these did not demonstrate people had been supported to take medicines as prescribed. The medicine names had been handwritten into the records, but there was no dosage information and the prescription instructions were unclear. For example, one medicine stated, "Laxido daily 1/2 morning or night." It was not clear if staff were meant to administer one, two or half a laxido, or what form the laxido took or whether morning or night time administration was preferred. The MAR stated "Paracetamol when needed 10ml" There was no guidance to inform care worker when to offer or administer paracetamol. There were three entries on the MAR. One stated "Left eye 8.50am" The other two entries recorded 5ml had been administered. A third medicine was listed as "Golden eye" there was no information about what this medicine was, how to administer it and there was one mark to record it had been administered once.

During the inspection we showed the deputy manager some best practice guidance for managing medicines in home care. After the inspection the deputy manager sent us updated care plans, but the information about medicines remained insufficient. For example, one person had two medicines listed as been "when required" but there was no information about how to identify when to offer and administer these medicines.

Although the dosage, form and timing of medicine was listed, there was no information about the purpose or potential side effects. This meant people were at risk of not receiving their medicines appropriately as there was insufficient information available.

The above issues with risk assessments and medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the registered manager sent us a new template risk assessment and told us they had added information about people's medicines to their care files. However, this had not been in place during the inspection and the processes of ensuring risks were appropriately identified and mitigated were not embedded.

People and relatives told us care workers were frequently late. One person explained, "They don't come on time. I can't expect them to be on time. [Care worker] showed me her phone and there's no travel time. It's ridiculous. They can't be on time if they spend the time they should with people. We can't expect them to be in two places at once, the one after me is meant to be at the same time." A relative said, "The rota doesn't allow them to be on time. They aren't allowed any travelling time. They do the best they can but it's very variable."

The provider used an electronic call monitoring system where care workers logged their visits using their phones. We reviewed the call monitoring information for three people and found visits were often taking place more than 15 minutes outside the agreed schedule. One person had nine out of 16 visits more than 15 minutes outside the schedule. Another person had 19 out of 52 visits more than 15 minutes outside the schedule. The third person had 28 out of 54 visits more than 15 minutes outside the schedule.

We reviewed the electronic call monitoring information for two staff members. This showed that staff were given impossible schedules with no travel time and overlapping visits on their schedules. One care worker was scheduled without travel time on 45 occasions and with overlapping visits on 27 occasions out of 140 scheduled visits. Another care worker was scheduled without travel time on 75 occasions and scheduled overlapping visits of care ten times.

Care workers were not staying the full length of visits. One care worker was more than 15 minutes short of the scheduled time on 69 out of the 126 visits, and overall delivered only 57 hours and 53 minutes out of 91 hours scheduled. The other care worker was more than 15 minutes short of the scheduled time on 59 out of 140 visits and overall delivered only 62 hours 47 minutes of 92 hours 30 minutes scheduled. This meant staff were not deployed effectively as they were give impossible schedules and were not staying the full allocation of people's time.

The above issues with staff deployment are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider told us they had added travel time to staff rotas.

The provider's information collection had stated they had ten staff vacancies when they completed the submission in March 2018. The deputy manager told us they continued to have this level of vacancies as there was always more work than they were able to deliver. They told us, "We are always recruiting and we always have vacancies." Records showed the provider recruited care workers from overseas via an agency who performed initial screening of applicants. Staff completed application forms and the provider carried out checks on their identity, right to work and criminal records both in the UK and in their home country.

The provider collected references from applicant's previous employers or where this was not possible character references were supplied. Interview records did not demonstrate staff were assessed on their competence, skills or attitude. However, staff were employed on an initial probationary contract where they completed training and worked only with colleagues until their suitability had been confirmed.

Staff meeting records showed staff discussed methods of preventing and controlling infection. We saw that personal protective equipment was available for staff and records showed staff arranged collection and delivery of gloves and aprons. Spot checks carried out by the deputy manager checked that staff were adhering to infection control measures. This meant people were protected by the prevention and control of infection.

Requires Improvement

Is the service effective?

Our findings

People told us they had a meeting to discuss their care before care workers started visiting them at home. Records showed assessments were completed, however the information within them was limited and not all sections of the assessments were completed. The assessments considered people's needs in different areas of care, including their personal care needs, mobility, domestic chores as well as communication. The level of detail in the assessments was extremely limited. For example, one person's assessment stated for their personal care, "Strip wash. Hair wash once a week." Their mobility was described as "Slow but OK." Each care file contained a body map and waterlow assessment to support the identification of pressure care needs. These were not completed in any of the files viewed.

People and relatives told us they had to explain their support needs to the care workers and could not rely on them having read the care plan. One relative said, "We always explain it, or the senior carer will train the new ones. Often they don't speak very good English, I'm not sure they can all read the care plans." People confirmed staff relied on them telling them what they wanted rather than arriving with knowledge from a care plan. One person said, "I have to tell them each time they send a new worker."

The quality of the care plans reflected the lack of information collected in the assessment. Care plans were task focussed and did not include information about how to complete tasks in a way that supported people to achieve their goals. For example, one person's care plan stated, "Assist with p/c full body strip wash carried out on the bed, assist with continence care ensuring a clean pad is being worn, assist with dressing either into a clean night dress or clean clothes of her choice." There was no further information about how to perform these care tasks in a way that reflected the persons preferences.

The lack of detail was discussed with the deputy manager who submitted updated care plans after the inspection. These contained slightly more guidance but still did not ensure care worker had enough information to provide appropriate care. For example, they were now advised to use disposable wipes and to be gentle but there was no further detail about how the person wished to receive care.

People told us staff supported them to prepare meals. People's experience of the support they received with meals varied. Some people had positive experiences, with one person telling us, "[Care worker] is very good. She helps me with my meals and always has a little chat with me." However, other people did not feel they were receiving appropriate support with their meals. One person said, "They [care workers] buy the food from the supermarket, but what they do with it beggars belief. They put it in the microwave sometimes it's hot but with cold in the middle, sometimes it's not edible it will have gone rock hard."

Where supporting people with meals was part of the care workers responsibility there was limited information about the type of foods people liked to guide care workers. For example, one person was described as living with advanced dementia. Their care plan instructed care workers "Prepare a hot meal of her choice" It also stated, "Encourage [person] to eat as much as she can including snacks." However, there was no information about what foods she liked and was more likely to choose.

The updated care plan contained more information about how this person ate but there remained no information about her dietary preferences. A second updated plan did contain a list of foods the person liked to eat. Records of care showed people were supported with meals, but the level of detail varied. One person's file contained detailed food and fluid monitoring as this had been put in place by the person's family. Another person's records simply recorded they had been served a "ready meal." This meant it was not always clear that people had been supported to eat and drink enough to maintain a balanced diet.

The above issues are a breach of Regulation 9 of the health and social care act 2008 (Regulated Activities) regulations 2014.

After the inspection the registered manager told us they recognised that care plans required more detail and submitted an action plan which included the timescales for updating people's care files.

People told us they were confident staff knew how to use the equipment and had the skills they needed to perform their roles. Records showed staff received supervision from their line managers. Supervisions included an assessment of the staff member's performance and included actions for the staff member to complete. For example, to complete training sessions or to improve their communication with the office. Staff completed online training courses which included an assessment of their knowledge. Staff had to re-take the courses if they did not reach the required level in the assessment. Staff were completing the care certificate. The care certificate is a recognised qualification which provides care staff with the fundamental knowledge required to work in a care setting.

Care files contained information about other professionals involved in people's care. For example, there were contact details for people's social workers within all the files viewed. One person told us the service had supported them to find a separate support worker to help them access the community. They said, "It's really very good. I can't get out by myself anymore but I went to the garden centre the other week, and into the garden this week. I hadn't been able to do that for a year. It's made a real difference to how I feel." We saw the provider contacted social workers and other services involved in people's care if they needed to raise concerns or make changes to support.

People told us they were confident care workers would support them to access healthcare services if they needed. One person said, "Oh [care worker] is very good with things like that. She'd call the doctor for me if I asked." A relative told us, "They [care workers] will call me to come and check if they are worried about anything. They know [my relative] very well now so can tell when something isn't right." Care workers told us they were confident to liaise with healthcare professionals when people needed. One care worker explained, "If anything is wrong the doctor or the nurse will visit. She had some scratches on her legs and we arranged the nurse to come."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in the community are via the Court of Protection.

We checked whether the service was working within the principles of the MCA. People's needs assessments

contained a section regarding power of attorney. If someone holds power of attorney it means they have been authorised by the court of protection to make decisions on behalf of the person. One person had a named attorney. However, there was no other information within the care file about this person's mental capacity or how to support them to be involved in decisions about their care. The care plan referred to providing food and drink and clothing of the person's choice, but did not give information about how this person made choices. Their relative had completed a care passport which contained clear information about how they expressed their views and choices. Staff told us they offered people day to day choices to ensure they were involved in their care. An updated template submitted by the registered manager after the inspection, included more space to explore people's decision making abilities. We will follow up on how these improvement have been sustained at our next inspection.

Requires Improvement

Is the service caring?

Our findings

People gave us mixed feedback about the attitude of care workers. Some people told us they found their care workers were caring and compassionate in their approach. For example, one person said, "I'm very satisfied. They are the best ones I've had." Another person said, "I get on very well with [care worker]. They immediately make it wonderful. When they talk to me I can understand. She does everything she can to help me."

Another person told us their experiences varied, they had developed a trusting relationship with their regular care workers but others had not had an appropriate attitude. They said, "I like the girl who comes to me now, but before there was one I refused. I told them I wasn't happy and refused to let them in." A third person said their experiences were also mixed. They said, "I used to get on with them very well. I don't know what happened but now they are really short with me. Some are quite rude. They talk at me not to me."

We contacted the registered manager about the range of feedback received and they sent us records to show they had discussed specific communication issues with care workers. They had also spoken to people to reassure them their concerns about care worker attitude had been taken seriously.

Care workers told us they had time to develop relationships with people, and this was facilitated by having regular schedules where they worked with the same people. The schedules viewed showed that care workers did work with the same people over time. Care workers told us they would spend time with people and provide comfort if they seemed upset during a visit. One care worker said, "Today [person] was sad. They said they were sad because they were alone. I started to sing and she laughed. She said thank you for making her smile. I reassured her I would be back. It's my job to help them relax."

As part of the assessment process the provider collected information about people's religious beliefs and significant relationships. However, they did not explore if people's religious beliefs had any impact on their care preferences. For example, it was not captured whether or not people practiced their faith and if they needed timing of support to vary if they wished to attend their place of worship.

The provider did not explore people's sexual or gender identity. This meant there was a risk people may not feel safe to disclose their sexual or gender identity and the significance of some of their relationships may not be recognised. Staff told us they "wouldn't want to offend" people by asking about their sexual or gender identity. However, people were asked about their marital status as a routine part of the assessment process.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring they meet the needs of people who identify as lesbian, gay, bisexual or transgender.

Care workers described the steps they took to preserve people's dignity while supporting them with intimate care. People confirmed their care workers followed these steps. People and relatives told us they felt care workers were respectful of their homes. However, one person did raise that care workers sometimes rushed

when using equipment which had led to damage to the decoration of their home. They were clear this was not due to a lack of respect, but rather a lack of time.

Requires Improvement

Is the service responsive?

Our findings

Some people and relatives told us they were involved in reviewing and updating their care plans. However, other people told us they had not been asked to provide any feedback or review their care. One person said, "I speak to [deputy manager] and she'll get it sorted." Another person said, "I can't remember when I last heard from someone at the office. They wait for us to raise things."

Care plans were reviewed at least annually and the service completed quarterly telephone reviews of people's care. However, as care plans were very brief it was not clear that people were always receiving personalised care, as their preferences had not been captured. The quality and detail in records of care varied. Where people's needs meant detailed recording of their food and fluid, wakefulness and position were required these had been completed. However, other people's records were very brief. For example, one person's care records showed, "Person care done" each day. The records did not consistently show people had received the support they needed to have their needs met. Staff meeting minutes showed the detail required in records had been explained to staff on more than one occasion. We will follow up whether this becomes effective in improving the quality of the records.

People were consistent in their feedback that they felt the service responded effectively when they raised issues or made complaints. For example, one person said, "At first it was difficult, with different care workers. They immediately made it wonderful when I asked them to." Another person said, "It's a bit difficult because it has chopped and changed a lot. But it has settled down. There was a time when I was not sure about the service. I had to tell them I was thinking of going before they got it sorted." A relative said, "We won't be pushed around. If I complain they listen. The quality can be very variable."

The provider had a clear policy regarding complaints, which included details of how to make complaints and expected timescales for response. The guide given to people when they started receiving a service included details of how to raise complaints. Records showed complaints were investigated and responded to in line with the policy. The registered manager completed thorough investigations into complaints made. We saw feedback was provided to complainants and where appropriate, performance management processes were followed with staff. For example, one staff member was required to repeat a training course following a complaint.

The service supported people who were identified as being in the last stages of their life. However, their care files did not contain details about what this meant in terms of their care. For example, it was not recorded if people had made decisions about whether or not to attempt resuscitation, or what types of treatment they did, or did not want to receive. Care workers told us they knew this, but had received the information from family members. One care worker explained, "[Person] does not go to hospital anymore. They want to stay at home. If there's something wrong a doctor or nurse will visit the home, but they won't go to hospital." Training for staff on end of life care was not included in the training matrix. After the inspection the provider told us information about resuscitation status was included in care files and staff had been enrolled in end of life training.

We recommend the service seeks and follows best practice guidance on ensuring people receive appropriate support at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

The deputy manager and coordinator completed regular spot checks on care workers. Twenty spot checks had been completed in July 2018. These considered the experiences of people using the service, and the performance of care workers. They also completed regular telephone monitoring about people's experience of care. Individual issues identified were addressed through supervision or via the complaints process as appropriate.

However, there was no effective system to check and audit the quality and safety of the service. Although the registered manager recognised that care plans and risk assessments did not contain enough information, they had not completed any audits of care files and risk assessments. The registered manager confirmed there were no routine checks or audits of the quality and content of care plans and risk assessments. Likewise, there was no thematic audit of complaints which meant opportunities for wider learning were not identified or addressed.

People gave positive feedback about their experience of care during the telephone monitoring completed by the provider. The telephone monitoring asked people about the timekeeping, and people did not raise the concerns they did with the inspector. However, issues with the duration and timing of visits of care were clear from the electronic call monitoring. These issues had not been identified or addressed by the provider.

The registered manager sent us a copy of the business development plan. This included the goals of developing both the workforce and the number of people receiving a service. However, the plan was vague and did not include any specific actions which would ensure the plan was achieved. For example, the first action in place to address the risk of a skills gap within the staff team was recorded as, "Your people are your greatest asset and investing in them will help your business grow. Through training programmes will close the skills gap and be beneficial for you and your employees." No specific training or development had been identified.

The provider subscribed to a policy and care management system, where template policies were provided and made available to the staff team. Providers using the service are required to update the policies with local details. The provider had not always done so, for example, the safeguarding policy did not include local contact details. The provider was not adhering to the recruitment policy which detailed how interviews should be conducted and recorded. Nor were advanced care plans in place as described in the end of life care policy.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the quality of the service and its organisation was improving. One person said, "There was trouble before, but it's much better now. It's taken a while to get there but it's sorted now." The registered manager, and deputy manager responded positively when we raised concerns and took action to show they understood the reasons for the feedback. After the inspection the registered manager sent us an

action plan about how they were going to address our concerns. The deputy manager told us the provider had recently appointed a new quality manager who was in the process of developing new quality assurance systems.

The provider's philosophy of care was included in the guide given to people using the service. This focussed on treating people with respect and promoting their independence and skills. While staff did not articulate their motivation for their jobs in terms of values, they described the importance of treating people with kindness. One care worker said, "It's my role to build trust and friendship." Care workers and office based staff described the registered manager as being kind and supportive. One member of staff said, "[Registered manager] has the human touch. It's always a calm atmosphere and if I bring a problem he will try to sort it for me. I feel very lucky to work here."

Staff told us and records confirmed there were staff meetings every three months. These were used to update staff on key policy changes, as well as to reinforce issues such as client confidentiality. We saw issues affecting care workers, such as changes to the scheduling were discussed.

The provider demonstrated they valued the staff who worked for them. As well as offering an incentive payment if staff referred new employees, compliments were shared. We saw staff were given gifts by the provider in recognition of compliments received. For example, staff had received flowers and chocolates when people had given positive feedback.

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 9 HSCA RA Regulations 2014 Person-centred care Assessments and care plans lacked detail and did not ensure people received support in line with their needs and preferences. Regulation 9(1)(b)(c)(3)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been appropriately identified or mitigated. Systems in place for the management of medicines were not robust. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding issues had not been appropriately identified or escalated. Regulation 13(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to monitor or improve the quality and safety of the service. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been effectively deployed to meet people's needs. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit notifications as required. Regulation 18(1)(2)(b)(ii)(e)

The enforcement action we took:

We issued a fixed penalty notice which the provider paid in full.