Ark Home Healthcare Limited

Ark Home Healthcare Westbourne Park

Inspection report

Stag House
42 Westbourne Park Road
London
W2 5PH

Tel: 07734876422
Website: www.arkhealth.co.uk

Date of inspection visit:
08 August 2017
14 August 2017

Date of publication:
26 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Ark Home Healthcare on 8 and 14 August 2017. The inspection was announced. We gave the provider 48 hours' notice to ensure the key people we needed to speak with were available. This was our first inspection of the service since it had registered with a new provider, Ark Home Healthcare Limited.

Ark Home Healthcare provides personal care and support to adults and children in their own homes. The provider had recently notified us that they had updated their statement of purpose to include children. At the time of the inspection the provider informed us they were not supporting any children and were providing a service to 81 adults, the majority of them were living with dementia.

The service had a registered manager who was present on both days of the inspection, who had worked in the service before it was registered with a new provider. 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 told us they did not receive their visits at the times they requested and this was more noticeable during the weekends. Action was not taken by the provider when this occurred which had a negative impact on them receiving safe care. People were provided with different staff during the weekends who were not familiar with their needs. People knew what to do if they were unhappy with the service but when they contacted the office to speak about their concerns their complaints were not satisfactorily resolved. There was a system in place to log and monitor complaints, however verbal complaints were not documented.

Pre-employment checks undertaken on staff were not always robust. Staff had received an induction and planned programme of training to ensure they had the required skills and knowledge to help people with the care they required. People told us staff were kind and caring and provided support in a way that respected their privacy and dignity. People received support with their meals and medicines when this was needed. Staff had completed training in the safe management of medicines and their competency had been assessed. Healthcare services were accessed by people when they needed help with their healthcare needs and guidance was available for staff to show them how to respond and report concerns when people became unwell.

Risk assessments contained sufficient guidance to minimise the likelihood of harm to people when being supported to meet their assessed needs, and safeguarding protocols were accessible for staff to follow when they suspected people were at the risk of abuse. Care records were personalised to meet people's individual needs and preferences, these were in the process of being rewritten to align with the provider's new procedures. Procedures and guidance in relation to the Mental Capacity Act 2005 (MCA) was followed which included steps that the provider should take to comply with legal requirements. People had access to advocacy, advice and resources to support them with dementia care. This ensured people's views and wishes were heard and enabled them to maintain their independence. Information was available in an

accessible format so they could better understand the services they received.

People had mixed opinions about how the service was run. Their views and experiences had not been sought through the use of surveys as the provider had only been in operation since May 2017, but checks had been carried out in some people's homes to assess the quality of care. Systems of audits were in place, however they did not operate effectively to monitor the quality of the service and identify the issues we found. Staff spoke positively about the training they received and the overall management of the service. The provider worked in partnership with other services to help deliver continuous care and sought new ways to engage with their workforce to help deliver better care.

We found four breaches of regulations relating to the management of risks to people's health and welfare, staff recruitment, receiving and acting on complaints and good governance. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk of avoidable harm because appropriate action was not taken when late and missed visits occurred, and people told us this was more apparent during the weekends.

There was enough staff; however they were not deployed to provide people with a consistent and reliable service. Recruitment procedures needed to be more robust and the provider had a plan in place to ensure this was done.

People told us they did not have concerns about their medicines. Staff had received training in the safe management of medicines and their competency was assessed.

Risks were identified and assessed to show how these risks were managed. Staff had received safeguarding training to enable them to identify and report incidents of abuse.

Is the service effective?

Good

The service was effective.

Staff had access to a planned programme of training to support them with their work performance and provide effective care to people.

People's consent was sought in accordance with the Mental Capacity Act 2005.

People were supported to access healthcare services and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives shared positive experiences about the caring and kind nature of staff.

Staff told us they treated people with dignity and respect and

there was an emphasis placed on maximising people's independence.

People were involved in making choices and decisions about their care and advocacy support was available to ensure their views were heard.

Is the service responsive?

Requires Improvement

The service not always responsive.

The provider was not always responsive to the verbal complaints that people raised. People knew how to make a complaint and their written complaints were investigated and resolved.

Care plans were personalised in order to reflect people's wishes and individual needs. These were being transferred onto the provider's newly designed care records. Information was available in different formats so people could understand their care plans.

The service had a clear set of aims to meet people's dementia care needs and these were applied in practice by the staff that supported them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some people told us the service was not well led and the service did not run efficiently. This was because of the difficulties with their care being delivered on time and concerns not being addressed.

There were processes in place to monitor quality to drive improvements within the service. However, some of these processes were not robust in identifying shortfalls and ensuring these were addressed.

Staff spoke positively about the culture of the service and felt valued by the provider who promoted an open and inclusive environment for their employees. They worked in partnership with other care providers to seek additional resources for the people they supported.

Ark Home Healthcare Westbourne Park

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.

We inspected Ark Home Healthcare on 8 and 14 August 2017. We gave 48 hours' notice of the inspection because staff could be out of the office supporting staff or visiting people in their homes and we needed to be sure that someone would be in. The inspection was announced on the first day and we told the provider we would be returning to continue with the inspection for a second day.

The inspection was carried out by two inspectors. An expert by experience made telephone calls to nine people and six relatives to seek their views about their experience of using the service. 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 spoke with a representative of the local authority to gather information and obtain their views regarding the service. We checked information that the Care Quality Commission (CQC) held about the service including any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

During the visit we spoke with a care coordinator and the registered manager and reviewed the records of eight people's care files, including their medicines records. We also looked at nine staff recruitment and training records, quality assurance audits and some of the records relating to the management of the service.

After the inspection we made telephone calls to 18 members of staff and managed to speak with seven of them.

Requires Improvement

Is the service safe?

Our findings

People were at the risk of receiving unsafe care because action was not taken when staff arrived late or missed visits, and this was more prevalent during the weekends. One person using the service commented, "Well it's alright through the week but at the weekends it's terrible. It gets all muddled up. I ring up the office and say 'no one's come' and they say 'Oh [staff] will be 10 minutes' but it's awful, my nerves just go to pieces. I sit and worry that I'm going to miss hearing them knock and it's a long walk down the hall to answer the door and I am afraid they will just go." Another person told us, "I get all sorts and they change the times just like that, they were coming at 11.30am or 12pm to give me my breakfast, well I'm diabetic that's no good" and a third person said, "Oh it's just confusion [staff] come and say 'they've (office team) changed the time when I'm coming tomorrow'. Well my morning visit, they don't come until 2pm and then that's it and they don't come back, no late evening call. They (office team) say that's all they can do, it's a restricted service at weekend. If the [staff] come in the morning I get them to put out my pills for later so I don't forget them."

Two people told us staff arrived on time but they received different staff at the weekends and were not informed of this beforehand. Relatives explained the regular staff knew their family member's needs well but the service had difficulty finding replacement staff when the regular care worker was off. One relative said, "The problem is when the regular carer is off, they can't supply someone sometimes, they tell us 'we haven't anyone for you today' and that's difficult."

The staff we spoke with told us they did not always have enough travel time to arrive at their visits at their scheduled time. They explained they had spoken with the provider in meetings about working closer to their geographical area but were aware this depended on the calls that needed to be covered in that particular area.

The provider used electronic call monitoring (ECM)) to check that staff arrived and left their care calls on time. The care coordinator showed us the ECM data and we saw how many visits people had each day and the times of their care calls. We checked four people's care calls over a four week period and found that staff arrived at their calls up to an hour late during the weekends. There was no information recorded to show why staff were late or what action was taken. For another person we saw that the provider had cancelled a call visit but there was no information to show why this visit was cancelled. The provider had an out of hours care team for people to contact in the event of any emergencies, and we asked for a copy of the records for the out of hours' service. However there was no evidence to show what action the on call staff had taken when people called to enquire why staff arrived late to people's homes or had missed their calls. This meant that call visits were not appropriately monitored, which increased the risk of people not receiving appropriate and safe care.

This above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager explained that since they had transferred over to a new provider they were getting used to the different ECM software and how to navigate this. They agreed to put records in place to

document how all missed and late calls visits were dealt with throughout the week and the out of hours' service. The registered manager explained that as transport was not as reliable during the weekends and there were a lot less staff available, people could be supported by different staff during this time. The provider was in the process of recruiting more staff in their geographical area.

Risks associated with people's care needs were identified and appropriately assessed. We found that risk assessments covered the overall risks to people's health, care and well being and the details of these assessments had been completed correctly to show how these risks could be reduced. They contained guidance to show how people were supported to manage or prevent risks associated with, for example, their medicines, home environment and finances. One person described how these risk guidelines were followed by staff when they were being supported in their home. They commented, "They do my shopping for me, they bring me the receipts and it all goes in a book and they sign it." Risk assessments were kept under review to ensure the provider was responsive to people's changing needs.

Recruitment checks were not robust enough. The registered manager explained that staff had transferred over to the new provider and the majority of staff had been working for the previous provider for a number of years. Staff recruitment files held pre-employment checks that had been sought before staff began work. This included an application form, identification and evidence to show that staff had the right to work in the UK. Two references were on file for staff, however we found that gaps in one staff member's employment history had not been explored and for a second staff member their references had not been verified. The registered manager agreed to verify these two references in accordance with the provider's recruitment procedures. Criminal record checks had been carried out and were up to date. However for one member of staff we found they had recorded convictions on file and their written statement did not fully cover this to ensure that a thorough risk assessment was completed about their suitability. Thorough background checks are important to ensure that potential employees do not pose a risk to people they work with.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

After the inspection the provider informed us they had sent off for additional work references and verification of references for staff. They further explained that a risk assessment had been completed to ensure that people were protected until this information had been received. Additionally the provider had resubmitted another criminal record check for a member of staff, were awaiting the outcome of this and would obtain further written statements that would be risk assessed and sent to panel for a final decision about the staff member's suitability. Up until this point the registered manager explained the staff member would not be lone working. We will check this during our next inspection.

Potential employees had been tested on their knowledge about working in care before being offered their position. This included an assessment that involved looking at an extract of a care plan to show a typical day in the life of a person and the questions asked if the candidates understood the information and if this was correctly written. These were appropriately scored.

People told us they were supported appropriately with their medicines. Comments included, "They do my pills, they just hand them to me, that's alright" and "They do all my medicines, they get permission to do that". And a relative explained, "They do [family member's] medicines from a dosette, that all seems alright."

Care plans held information about people's prescribed medicines, how they should be given, and if relatives or health practitioners were involved with this area of their care. Procedures were accessible to staff and

contained information about the importance of the safe management of medicines, for example, staff were only permitted to assist people with medicines after the risk assessment was completed and staff had read this. We found that all people's file's held an up to date medicines risk assessment, which included the level of support they required and indicated where people were able to take their medicines independently. We checked the medicines administration records and these were being filled out correctly with the exception of one. We pointed this out to the registered manager who explained that she had not yet audited this person's records as they were collected and audited monthly. The staff we spoke with explained they had received medicines training and their competency was regularly checked. In order to reinforce their understanding of the safe management of medicines we found that Care Quality Commission guidance about medicines in domiciliary care had been printed off for staff to read alongside the provider's medicines policy.

We asked people if they felt safe and supported with the care and support that was delivered by the provider. They commented, "I do feel safe with them, they are nice" and "I feel safe with them and I can trust them." Relatives commented, "I am sure [my family member] is safe with them, [they] have regular carers" and "I am happy that [my family member] is safe with them, I know the carers so well and have a regular carer."

The safeguarding policy was fit for purpose and provided guidance for staff on how to protect people from harm; which was further supported by a programme of safeguarding training. The training staff completed ensured they understood how to recognise and report incidents of abuse and staff were able to describe their understanding of this. Comments included, "If I see different marks on the body or different behaviour I would call the office or contact the police" and "It could be the way they respond to you, they may not want to tell you but if you give them more time, they will eventually open up and I would have to report this to the office." The registered manager understood their responsibility to report cases of abuse and knew what actions to take in accordance with the procedures. We had been notified by the provider about one safeguarding incident of alleged neglect. At the time of our inspection the provider had gathered information about the case and submitted this to the local authority to be further investigated. Staff had access to the provider's whistleblowing policy which included telephone numbers for organisations such as Public Concern at Work who are a whistleblowing charity.

Good

Is the service effective?

Our findings

Staff had received ongoing training and had completed an induction before commencing their role. One member of staff told us, "I have completed training with supporting children and PEG tube feeding and how to complete the charts; I can always talk to the manager if I have any problems."

The registered manager told us that staff were still adapting to the organisational changes with the new provider and were being fully inducted into the new procedures along with the training programme. We checked the staff files to see how they were supported to develop their knowledge, practice and skills. Records show that staff had completed or were in the process of completing the Care Certificate induction and had refreshed and updated their skills in areas of basic life support, food hygiene, fire safety and pressure sore awareness. Other files we viewed demonstrated that staff had received training that comprised health and safety, first aid, moving and positioning, catheter care, dementia and the Deprivation of Liberty Safeguards.

Staff told us that they received one to one supervision and support and discussions about their work performance and we found that appraisals were clearly evidenced in their records along with any recognised national vocational qualifications they held.

People's consent to care was sought in accordance with the Mental Capacity Act 2005 (MCA). The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The staff we spoke with described how they offered people choices and asked for their consent before supporting them with their individual needs, and shared examples of how they supported people's choices and respected their rights. Care plans had been signed by people or relatives to show they had agreed to the care that staff helped them with in their own homes and the wider community. Additionally, consent forms were held in people's files to evidence they had agreed that staff could access their home with a safe key and third parties involved in their care could view their confidential care records, where this was required. For one person an MCA assessment had been undertaken about a specific decision about their care and they were supported to have their finances managed by the local authority in their best interests. For a second person we found they had been appointed a trusted person to make decisions on their behalf for their health, welfare and finances.

People told us they were helped to have sufficient food and drink. They commented "I just have microwavable meals all the time, well I have to, for speed you see" and "My carer usually comes and wakes me up with my porridge and my tea which is lovely, then comes back at 6pm. My friend makes my dinner and puts it in the fridge, so [carer] just has to warm it up, so that's alright." And a relative said "They make all

meals for [my family member], just as well they do or [he/she] wouldn't eat at all."

Care records showed people's dietary needs were assessed to demonstrate how they should be supported with their meals. Some people had their meals delivered to their home and others needed support with the purchase, preparation and storage of their groceries. For one person, records showed they had no specific food preferences but required support with a supplementary drink. For a second person their records showed they were at risk of dehydration and staff were advised to support the person follow a dietitian's plan and that food items should be stored safely. Records evidenced the plan was being followed. A staff member commented, "We make sure they eat a well-balanced diet and make sure they are not malnourished." For a third person, their care plan did not specify what the person would like to eat, but documented they had a small appetite and the daily records showed a variety of meals they enjoyed and consultation with the person about their preferred foods. The provider had sent an email alert to staff as a reminder to monitor one person's meals as they were at risk of eating foods that would have a negative impact on their health. This guidance had been given in response to information received from a health care professional. This evidenced that the provider followed the guidance of health care professionals to ensure people's individual needs were met effectively.

People had access to healthcare services and were further supported by health practitioners to help manage any physical and mental health conditions. Hospital transfer sheets were in place which given to emergency medical services so they had clear information about people's health conditions before admission to hospital. Care records contained information about people's specific health needs such as stoma and catheter care and included the input of districts nurses to manage these. The registered manager explained that staff had to undertake specialised training before supporting people with these areas of their care. At the time of the inspection the provider had not received any referrals for people who required support with pressure area care, however records confirmed that staff had received training for this in the event people were referred to the provider who needed this specific care. People's files contained a document called an 'alert framework'. This was used as a guide for staff to inform them what to observe and what they should do if they had concerns that people were becoming unwell. The framework advised staff to check any changes in people's speech or breathing, changes to their skin, their behaviour and note if their movements were different. Notes evidenced that when staff had concerns about people's health and wellbeing they would contact the office who in turn, would relay any concerns to their allocated health practitioners for escalation and action.

Good

Is the service caring?

Our findings

People told us they received support from caring and kind staff. They also confirmed that their needs were met by staff to a good standard. They commented, "The regulars carers are wonderful, I couldn't ask for better, they do everything for me", "The carers that come are great, [staff name] is very good, very tidy" and "My regular [staff] are wonderful." And a relative said, "I can't praise them enough."

People benefited from a culture that was aimed at maintaining their independence. Care records showed that conversations had been held with people about their psychological well-being and their interactions with others to establish if they had sufficient support in their community and at home. For example, the provider explored if family, friends or neighbours contributed to people's care and the importance of these relationships, and if they attended activities in the wider community to help reduce social isolation. For one person we found that the provider had written to the local authority to increase the hours of their care package so they could be supported to visit a healthcare practitioner with staff to discuss their overall well-being.

Staff spoke about the reasons they enjoyed working with the people they supported and told us more about their job role. Comments included, "It's the satisfaction and knowing they are safe, well fed and their personal care is all done, they also have someone to talk to" and "From the beginning [person's name] was very happy with me, I like to be caring." Staff explained when they supported people with personal care this was done in a dignified way that respected their privacy. A staff member commented, "I handle everyone differently; some clients want their windows, as well as the curtains closed when giving personal care so they don't get cold, and when I am finished they ask for their windows and curtains to be reopened."

People were supported to express their views and be involved, as far as possible, in making decisions about the care they chose to receive. One person told us, "They come and I tell them what to do, they are all nice, they do everything, some will say 'is there anything more I can do for you'?." Daily records contained pre-printed questions to help staff document how they reached the conclusion that people's care needs were fully met. For example questions asked and staff noted how consent was given, if staff noticed any missed medicines, if finances were managed, to ensure people's nutrition and hydration was checked and if they had read the care plan.

Advocacy support was accessible to ensure people living with dementia, their families and carers had their voice heard. The provider had a 'dementia voice nurse service' who provided guidance and representation to help people with personalised support planning, their medicines and symptom management, hospital discharge and helping other professionals understand dementia and associated symptoms. We found that when people's health deteriorated the provider had clear end of life plans available that reflected their views about their end of life wishes.

Records showed the provider sought comments and compliments about the service and the provider had received a written compliment from a relative that read, "Once again a big thank-you for all your help with [person's name]."

Requires Improvement

Is the service responsive?

Our findings

Responsive action was not taken when people had complaints about the service. The majority of people we spoke with told us the provider was not responsive to the verbal complaints they had raised. People using the service said, "The [staff] come and I tell them what to do, some of the new ones don't have a clue but my regular is alright, if you say something to the office nothing happens", "I rang the office up to complain but they say 'you're flexible' well I don't know where that came from. I might have been years ago but I can't be now, they don't tell you nothing, it's the [staff who visit the home] who let you know" and "If you say something to the office nothing happens." One relative told us they made a written complaint and this had been resolved. A second relative told us they explained to the provider that a staff member did not speak their relative's language but this had not been acted on, "We had a review a few months ago, we told them about the carers [language] but [the staff] are still coming, that's not right. You ring the office but it doesn't make much difference. A third relative told us they had no complaints and said, "The office is okay if you ring them, we haven't had a complaint, I can't think of any improvements."

People were provided with information about how to complain about the service if they were dissatisfied. There had been one written complaint since the service registered as a new provider, and action had been taken to resolve this. The complaints policy recorded timescales for complaints, comments and suggestions to be acknowledged and responded to. It read that complaints whether verbal or written would immediately be recorded and that people would be informed of who was dealing with the complaint. To further ensure progress was being made, investigations records were monitored and updated weekly and recorded on a 'complaints tracker' to be sent to the senior manager to further evaluate. However, there were no written records to evidence that where people had raised complaints verbally, action was taken to resolve these. We found the provider's policy had not been followed.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

People's needs were assessed and their views were sought before they began to use the service, to gain a better understanding of their needs and how they would like things to be done. A clear plan was developed to meet their needs, which was based on this information. These plans held information about people's day to day routines, previous occupations, well being and significant others to ensure that their wishes, aspirations and preferences were captured as clearly as possible. Staff further contributed to this based on their shared understanding of each person's specific needs. A staff member said, "The care plans are very clear to read, but I always speak with people to make sure I am following this correctly."

Care plans noted people's interest's and lifestyle choices so staff could build trusting relationships with them and converse about the things they liked to do and how they would like them to be done. These records were personalised and noted people's expectations about how they wished to receive their care. They noted people's comments and thoughts about their care such as, 'I would like my flask filled with hot water so I can have a hot drink' , 'I like watching antique shows, soaps and talk shows' and 'call me [person's name], I like to do as much for myself as possible'. For one person, we found they had a dementia outreach

worker and the guidance in their plan made reference to the location of white goods in their home and instructions on how staff and the person would operate these. We read about the foods they preferred to eat and how they liked to relax in the summer months and where their personal records would be located in their home. People were supported to maintain their independence and pursue interests that mattered to them. The provider had an 'activity plus' service to help people living with dementia or memory problems get involved in social networks and offered a wide range of activities that could be therapeutic to their well-being.

We received mixed views about whether people had received a recent visit from the provider to review their care records. "Well [staff name] comes and does the book and asks about things, no idea about a care plan", "They came from the office to check the care plan about a month ago", "I really don't think anyone has been out to check, maybe a while back" and "I can't remember anyone ever coming to check with me." Relatives of some people we spoke with told us their family members had received a review of their care plan and said, "We had a review about a month ago", "The office has been very good at letting us know if there is a problem and we do have reviews" and "We did a care plan and I am involved in reviews and stuff."

Quality assurance visits were to be carried out in people's homes every eight weeks to review their care package, in line with the provider's own procedures. The new provider registered in May 2017 and was in the process of transferring people's existing care plans onto their paperwork, and care plans were being rewritten to ensure that they contained correct and up to date information. The registered manager explained they were still in the final stages of completing and delivering these records to people's homes. The care plans we looked at during our visit contained evidence of reviews having taken place with people to include their relatives or representatives.

People's communication and cultural needs were highlighted in their care plans so the provider could match them with staff to meet their individual needs. Records noted people's country of origin and the languages they spoke to ensure they could be fully understood. Our review of a sample of care plans showed that two people had requested staff who spoke their language and we found this need was met. One relative said, "We have the same carers twice a week because they speak [my family member's] language." The service user guide highlighted that information was available in large print, other languages, braille, video or audio cassette. The guide was clear and explained the tasks that staff could carried out and the tasks they could not. The key policies and procedures were outlined such as support for money handling, cancellation of services, quality assurance visits and the Data Protection Act 1998. The guide also made reference to the fact that Care Quality Commission inspection reports would be made available on request. This meant that people who did not have access to the internet could obtain hard copies of the written reports to find out about the performance of the service.

Requires Improvement

Is the service well-led?

Our findings

People had mixed views about how the service was run, some people explained the service was well run and told us, "It's very good" and "The office is quite helpful if you ring them, I am satisfied with it as long as they don't change my carers." However some people disagreed and said, "They [office staff] do not help you at weekends" and "It's just when the regulars are not here that it all goes to pot and you ring the office and say and they say 'you are flexible' it's a cheek." And a relative said, "We are having a joint meeting soon but it has been so distressing and so tiring trying to get anything done."

Quality assurance systems were not operated effectively as they had not picked up the issues we identified. Although some of the areas we checked had been identified through the provider's audit processes, these did not pick up concerns relating to late and missed visits, monitoring of the out of hours calls and responding to people's verbal complaints. The registered manager described how the audit process worked and we saw there was a system of audits in place for care records, staff recruitment, performance and training. These audits were signed to show they had been done, however some areas were not fully completed and there was no comments or findings recorded to verify what action was required. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found that the audits for medicines contained more thorough information and evidenced if medicines had been given as prescribed, if the applicable code was recorded on the medicine administration records (MARs) and if staff legibly recorded the correct dates and people's names on these.

The registered manager had transferred over to work for the new provider and explained the organisation had been supportive during the period of transition. The provider's senior management team had attended the office and worked alongside other staff to help with the organisational changes. Further training had been given to support office staff to familiarise themselves with the paperwork and use of the new systems such as the electronic call monitoring (ECM) software.

Spot checks were carried out in people's homes to observe if staff carried out the appropriate care and support in adherence with their care plans. These checks picked up and identified good practice and highlighted where staff required further support. We found that action was taken after the observations such as an extension of a staff member's probation period, further spot checks and training to improve their skills. Records showed the comments that people had made about their care during these checks and if there were safeguards in place to ensure people were protected from harm. Staff performance during spot checks was rated to show if the care carried out was poor, average or good.

People and their relatives told us they had not received any surveys from the provider to seek their views and listen to their experiences to improve how they delivered care to them in their home. The provider was in the process of sending surveys out as they had recently registered with the Care Quality Commission (CQC) to provide personal care to people in May 2017. New care files had been produced to replace the existing information in people's homes. Content included clear guidelines for people's medicines, finances, communication records, and their newly drafted risk assessment and support plan.

The provider had a straight forward management structure that provided clear lines of responsibility and accountability. Staff we spoke with had a good understanding of their roles and spoke positively about working for the provider. Staff members expressed that they felt supported and listened to, and when they sought advice the management team were helpful. Comments included, "Since I started it has been a well managed place, they have now joined a new company, altogether I am happy with the agency" and "The service has one of the best manager's and the care coordinators are very good, they are very friendly and encouraging, I plan to continue working with them", "They are trying their best, so good, so helpful "and "They are an excellent company."

We found the provider was working with new technology solutions to better connect with their workforce across all of their services. This led to the provider launching their own Ark App that staff could download onto their phones and connect with the offices and their colleagues, access information about the services and feedback any concerns they had. In addition to this, listening lunches had been facilitated by the senior management team to seek staff member's opinions and feedback and address any concerns they had. Records evidenced a good number of staff had attended. The agenda was based on discussions that covered the new ways of working with the provider, rotas, out of hours services, annual leave and maintaining professional boundaries. Guidance was also in place for staff about the CQC and how to meet the five key lines of enquiries and the importance of being open and transparent.

The registered manager explained how they worked in partnership with other agencies due to the locality of the office, which was based in a dementia friendly building with other providers of health care. This included the NHS and the dementia and memory resource centre, which meant the service had access to information, advice and knowledge to enable them to refer people to other health care services.

The provider compiled a service user annual report that captured the overall performance of the service, which was completed monthly by the registered manager. This showed the number of care visits that were delivered, the average length of these and how many visits were planned. This also held information in relation to staff retention, how many people currently used the service, and the number of safeguarding and medicines concerns reported. The reports were used to check key performance indicators against all the provider's services in other locations throughout the year and identify any trends, activities and financial performance to share with their stakeholders. This demonstrated the provider used effective monitoring tools to establish if the service delivered good quality standards of care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints How the regulation was not being met: Complaints were not investigated and necessary proportionate action taken in response to any failure identified by complaints. Regulation 16 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met:

	Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not operate effective recruitment and selection procedures to ensure the appropriate checks were undertaken on employees. Regulation 19 (2) (a)