Nestor Primecare Services Limited

Allied Healthcare Redcar

Inspection report

Room 311, The Innovation Centre
Vienna Court, Kirkleatham Business Park
Redcar
Cleveland
TS10 5SH

Tel: 01642777739
Website: www.nestor-healthcare.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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 15 August 2016. Both days of inspection were announced because we needed to be sure staff would be at the office. This was the first inspection for the service which had registered on 25 February 2015.

At the time of inspection, Allied Healthcare Redcar provided care and support to 174 older people living in their own homes in the Redcar and Cleveland area. This included people living with a Dementia, mental health difficulties and physical health difficulties. The local office in Redcar was centrally located for staff.

The registered manager had been registered with the Commission since 30 June 2016. 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.

Risk assessments did not reflect people's needs and people's risks had not been regularly reviewed. Staff did not always act upon risks when they were identified.

Medicines were not managed safely. Risk assessments for medicines had not always been completed. No action was taken by staff when people did not take their medicines as prescribed. There were gaps in medicine administration records (MAR).

Staff had not always recognised safeguarding concerns. This meant safeguarding alerts had not always been made when needed.

Robust recruitment procedures were in place. The service sought two references from previous employers for each person and a 'Disclosure and barring services' (DBS) check before an offer of employment was made. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

We heard mixed reviews about staffing levels. The number of missed calls had reduced since the registered manager started at the service. Staff told us they didn't always have the time needed because travel time, staff sickness and people's complex care needs impacted upon the time allocated during each call. People told us staff provided the care they needed, but it could be rushed at times.

Information about 'Do not attempt resuscitation' (DNAR) certificates was not up to date. This meant staff did not know which people had a certificate and whether it remained valid.

Staff carried out mental capacity assessments even when people had capacity. These assessments should only be carried out when there are concerns that people may not be able to give their consent.

There were gaps in supervision and appraisal records. Records did not show if these meetings had been completed or if there were any areas where further action was needed.

Training in all areas was not up to date. There were no records to show whether staff had received training in the Mental Capacity Act (2005), Deprivation of Liberties Safeguards and dementia care.

All staff were supported through an induction programme which included training, shadowing experienced staff and attending reviews.

People told us they were supported with their nutrition and hydration. They confirmed staff always made sure they had a drink and a meal before they left.

Staff supported people with their healthcare needs. We saw staff taking the action needed when people became unwell.

Care records did not always match people's needs. We found they were not regularly reviewed. Care records were not always updated when changes in people's needs had been identified.

A small number of complaints had been made. Records were available to show the action which had been taken to resolve the complaint and the outcome.

Some audits had been carried out; however there were gaps within them. We also noted a lack of action plans in place to make the required improvements.

There were gaps in all records looked at during inspection. These had not been highlighted during the registered provider's quality assurance processes.

Staff told us the registered manager was accessible and they felt supported by them. People told us the quality of the service had improved since the registered manager came into post. People spoke positively about the service.

Staff had access to regular meetings and were kept informed of changes which were occurring at the service. Staff told us they felt able to voice their opinions and concerns at these meetings.

People we spoke with told us they were happy with the care they received and had a good relationships with the staff who provided care to them.

People told us their privacy and dignity was maintained. They told us staff gave them the time they needed whenever care and support was carried out.

People told us they were involved in their care and staff sought their consent before and care and support was carried out.

We found four breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Medicines were not managed safely at all times. We raised safeguarding alerts in relation to medicines.

Risk assessments did not always reflect people's actual risks and were not consistently reviewed in a timely manner.

There were mixed reviews about staffing levels. Staff told us they didn't always have the time they needed to provide care and support to people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not aware of which people had a 'Do not attempt cardio-pulmonary resuscitation' certificate or whether they remained valid.

Staff carried out mental capacity assessments (MCA) for people who had capacity. This goes against the principals of the mental capacity Act.

People were supported with their nutritional, hydration and healthcare needs. Staff took action when needed.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care and support they received.

Staff respected people's privacy and dignity.

People told us they had good relationships with staff and were involved in their own care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always contain the information needed to ensure personalised care and support was carried out.

Regular reviews of care had not always been carried out. Where they had been completed, there were gaps in the records.

Complaints had been made and records were in place to show that they had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance checks had not highlighted the issues we found during our inspection.

People and staff told us the quality of the service had improved since the new registered manager came into post.

Notifications were submitted to the Commission when required.

Allied Healthcare Redcar

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 service was registered on 25 February 2015. This was the first inspection of this service.

One adult social care inspector and two pharmacist inspectors carried out an announced inspection on 9 August 2016 and one adult social care inspector visited again on 15 August 2016. This was an announced inspection because we needed to make sure someone would be in the office when we visited. Two experts by experience carried out telephone calls to people and their relatives. These are people who have experience of using services or who have been involved in adult social care.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned with the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service and they told us that they had been concerns raised about the service relating to missed calls and staffing levels at the start of 2016, however some improvements in these areas had been noted.

The registered provided completed a provider information return (PIR) when we asked them to. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of the inspection, 174 people were using the service and were supported by 93 care staff.

During this inspection, we visited six people in their homes to check their prescribed medicines. We spoke with a further 35 people and seven relatives over the telephone. We also spoke face to face with the registered manager, two team leaders and seven carers.

We reviewed 13 care records, five recruitment records, five induction records and five supervision and appraisal records. We also reviewed records which related to the day to day running of the service, such as health and safety checks and audits.

Inadequate

Is the service safe?

Our findings

Risk assessments had been carried out for people's homes which included accessibility to people's properties and health and safety for people and staff. People also had risk assessments in place for their individual needs, such as nutrition, medicines, falls and pressure area care. We found that risk assessments were not always in place when needed and where they were in place, did not always reflect people's actual needs. Risk assessments were not consistently reviewed within a timely manner and were not updated when people's needs changed. When we looked at people's risk assessments and care plans it was unclear whether risks remained.

When we visited one person, we saw staff experiencing difficulty accessing the property because there was a mobility scooter blocking the entrance hall. Although the risk assessment stated the hallway was cluttered, it did not highlight the risk of minimal access and trip hazards caused by wires charging the mobility scooter. The risk assessment did not show what steps had been taken to reduce the risk of harm.

The arrangements for medicines management did not always keep people safe. We spoke with staff about medication and reviewed the registered provider's medication policies. We visited six of these people in their own homes to make sure that appropriate arrangements were in place to manage medicines safely.

During inspection we identified that one person hid their prescribed medicines. A team leader told us this had been happening for the last three weeks because the person did not want to take them. Although the team leader was aware of this person's wishes, no action had been taken to address this. The person's care plan had not been updated to reflect the person's decision and the person's GP had not been contacted to ask for a review of their medicines. No action had not been taken to remove the excess medicines from the person's home; when we asked staff they could not be sure how much excess medicines were in the person's home. Staff had also not considered whether it would have been appropriate to make a safeguarding alert to the local authority. We made a safeguarding alert following inspection.

The level of support that individual people needed with their medicines was not accurately documented in their care plan. For one person we visited, the medication risk assessment stated the person required their medicines to be administered by staff but we saw on the medication administration record (MAR) that one medicine was left out for the person to take later. No risk assessment had been completed to give assurance the person knew when and how to take this 'left out' medicine and that they could manage this safely. A second person's care plan stated they were visited four times daily; however their daily record showed they were only visited twice daily. This meant there was a risk of harm because people were not supported to take their medicines as prescribed. We raised a safeguarding alert for these people following inspection.

We found the administration of people's prescribed medicines was not accurately recorded. Documents care workers signed to record when people had their medicines did not always clearly demonstrate which medicines had been administered on each occasion. Details of the strengths and dosages of some medicines were not recorded or were recorded incorrectly. We also saw gaps in the records kept for all the people we looked at, which meant we could not tell whether their medicines had been given correctly.

Medicines were not always given as prescribed. One person was prescribed Paracetamol tablets for pain. On ten occasions between the 25 June 2016 and 10 July 2016 the time interval between doses recorded on the medicine administration record was less than four hours. This meant there was a risk of overdose because the interval between doses should be at least four hours. A second person was prescribed a medicine used for blood thinning. Care staff had administered a higher dose than that stated in the treatment summary dated 8 July 2016. The registered manager investigated this during our inspection. We raised safeguarding alerts with the local authority about both of these issues. A third person was prescribed lactulose four times daily. Their administration records indicated that this was given once daily at night between 20 June 2016 and 27 June 2016 where records were up dated to say two tablets to be taken four times daily. Lactulose is not available in the tablet form. This meant records did not accurately reflect the treatment people had received. In addition, not administering medicines as directed by the prescriber increases the risk of the experiencing a decline in health or wellbeing.

Several people were prescribed topical creams and ointments. Many of these were applied by care staff. The service used body maps in people's care plans which described to staff where and how these preparations should be applied. However, these were not sufficiently detailed. For some people body maps were not available or the body map referred to several creams on the same chart and for other people the frequency or area of application was not specified. One person had topical creams that were not recorded on their medicine administration records or in their care plans. We were told by a carer that these were temporary. This meant there was a risk that staff did not have enough information about how to safely apply them.

We looked at the guidance for staff about medicines to be administered 'When required,' which stated these should be recorded on the 'Medication list and support form;' however we found that this guidance was missing for the people whose records we looked at. Insufficient information increases the risk of the service user's medicines not being administered correctly and therefore experiencing a decline in health or wellbeing.

This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Safeguarding alerts had not always been made when needed. We found that some staff displayed limited knowledge of safeguarding and the procedure which they needed to follow if they suspected abuse could be taking place. When we asked staff what they would do if they suspected someone was at risk of abuse, one staff member told us, "It depends on the concern. I would log it in the care records and monitor it or I would take it into the branch [local office]." Another staff member told us, "I would inform the [Registered] manager or speak with the person's social worker." During inspection we identified some areas where we considered whether safeguarding alerts were needed. In each of these cases, staff had failed to inform the registered manager about the issue. When we spoke with the registered manager they took immediate action to investigate each of our concerns. They told us that they were working to address the culture at the service which included staff not notifying them of all concerns relating to safeguarding. To do this they needed to embed the staff's responsibility and duty of care to people to ensure all appropriate action was taken to safeguard people from abuse.

This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We looked at the recruitment records of the five newest members of staff. Records showed that thorough procedures had been followed to make sure staff were suitable for the role they were being employed to carry out. Completed application forms and interview questions were available. We could see that a

Disclosure and Barring Services (DBS) check and two checked references from previous employers had been sought. Where a second reference could not be sought, there was evidence of decision making taking place. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

Prior to inspection, we were aware that there had been concerns with the service relating to missed calls. However since the registered manager came into post we could see that the number of missed calls had significantly improved. The registered manager was aware that missed calls did occur at times, however action was taken to reduce the risk of reoccurrence. We could see that the actions were working because at the time of inspection, they had been none during that month.

During inspection we did received mixed reviews about staffing levels from people, their relatives and staff. The registered manager told us, "We have had a rough patch with staff because we lost a number of staff when another domiciliary care agency started in the local area. We've also had staff leave because of changes in shift patterns and working in specific geographical areas." Following our inspection, the local authority informed us that the registered manager had taken the decision to reduce their availability to because they were unable to meet these demands. This meant the local authority were able to take swift action to ensure people's care needs were met by another registered provider.

Staff told us there were enough staff on duty, however they became under pressure when there was sickness and when staff had left the service. Staff told us travel time could be problematic, however this was often unforeseen. People spoke positively about staff. Everyone we spoke with told us that staff generally turned up on time and they had access to a regular group of care staff. People told us staff stayed for the time allocated to them. One person said, "The girls are all good; they come pretty much to time and will do anything I ask." Another person told us, "I have the same carer's, they come four times daily, I have good care and timekeeping is good." We spoke with people about evening calls and a small number of people told us that calls could be rushed and staff did not stay for the allocated about of time. One person told us, "I don't like them coming early as sometimes they need to help me to bed and I don't like going too early as makes for a long night." We discussed this with the registered manager following our inspection and they took action to change the person's call time in line with their preference.

The registered manager told us, "Rotas are dispatched every Friday and these stated the times of calls and the staff members allocated to them. However we received mixed feedback when we spoke with people. One person told us, "I never know who is coming or what time." Other people spoke positively about the rota they received. They told us this was a new and welcome addition.

The registered manager told us they had a central on-call system which all calls divert to when the office was closed. They also told us this had been a successful move and has taken the pressure off care staff." We could see that people could always speak to someone if they needed to and staff could access an appropriate person if they needed to cover sickness or if there was an issue with a person using the service.

Requires Improvement

Is the service effective?

Our findings

There were no systems in place to show how many people using the service had a 'Do not attempt resuscitation' (DNAR) certificate in place. Whilst staff understood the requirements of this certificate, staff did not know if the people had a certificate in place and there was no information in people's care records to show whether a certificate was in place. This meant we could not be sure if staff had the information they needed to respect the wishes of people.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. Mental capacity screening assessments had been carried out for people when there was no evidence that people lacked capacity to make their own decisions. The registered manager told us that their policy stated that they must carry out these screening assessments. We recommend that the registered provider refers to the Mental Capacity Act 2005 and ensures all staff are working within the parameters of the act which states that we must assume people have capacity unless we have evidence to think otherwise. .

Staff had received supervision and appraisal sessions, however there were gaps in staff supervision and appraisal records. This meant that we could not be sure if they had been effective for staff. We found some staff records had been duplicated. Records of spot checks to establish if staff were meeting the requirements of their role and to check they remained competent to provide care and support to people were incomplete; this meant that we did not know if they had been completed and if staff were competent.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We reviewed the training records of ten care staff which were sent to us following our inspection. We could see that staff had received training in fire safety, food hygiene, health and safety, infection prevention and control, moving and handling, safeguarding, first aid and medicines management. There were no records to show whether staff had received training in the Mental Capacity Act, Deprivation of Liberties Safeguards and dementia care. From speaking with staff and the registered manager we established training in these areas had not taken place.

This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Consent records were in place for photographs, to share information and to provide care and support to people. They were no systems in place to make sure consent records were updated each year or as people's capacity changed. However the registered manager told us they were now aware of this and team leaders

were updating these records alongside care plans. All staff told us they asked for people's consent before care and support was given.

All new staff undertook a four day induction programme which included equality and inclusion, fire safety, infection prevention and control, safeguarding and health and safety. Staff also shadowed more experienced members of staff and became familiar with the policies and procedures of the service. In addition to this, staff were monitored during their three month probationary period which included an observation of practice, a telephone consultation after their first lone working call, and face to face meetings every four weeks.

The registered provider's 'Performance management' policy [for supervision and appraisals] stated that all staff should have access to planned and regular performance management which consisted of field supervision at three and nine months, a performance and development review at six months and an appraisal at twelve months. Field supervisions were used to monitor people in the workplace whilst providing care and included a competency check of staff in areas such as medicines, infection control and moving & handling.

Staff received one supervision session each year; this is a formal method of supporting staff to carry out their roles to the standard expected. From the field supervision records, we could see they included an observation of practice, a check of the care records and MARs and questions designed to check their knowledge and competency. Field supervisions did not include a supervision session.From speaking with the registered manager, we could see that staff received one supervision session each year. All staff spoken with felt able to approach the registered manager about any concerns which they had.

People were supported with their nutrition and hydration. All staff spoken with told us that they always made sure people had something to drink, of their choice when they visited them. Staff told us they could help to prepare meals for people if they needed to. Four people we spoke with told us that staff heated microwave meals for them or made a sandwich for them. We could see that staff monitored people's nutrition and hydration and recorded this is people's daily records. One person told us, "Recently I've not been eating and the carers told my family so they can keep an eye on me." Staff told us that they completed a nutritional risk assessment when they suspected people may be at risk of malnutrition. They also told us they spoke with people's families and encouraged people to see their GP.

We asked staff about the action they took if they found a person using the service was unwell during their visit to them. One staff member told us, "I'd check them, then ring the family and the GP. I'd tell the branch and log everything in the care records for the next carer to monitor. One person told us, "My carers will ring my family, or my doctor if I am not well." During inspection, staff made us aware that someone they were supporting required medical attention. Staff told us they were concerned that this person was no longer able to eat because of the pain they were in. Staff spoke with the person's GP and they visited the same day.

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received from staff. One person told us, "The carers are super. Very Good. They come four times per day. I would be stuck without them." Another person told us, "My carer asks if I need anything else before she goes and I appreciate that."

From speaking with people we could see how they valued staff and felt that they were important to them to maintain a good quality of life. One person told us, "I wouldn't be here if it wasn't for the care I am given from certain carers." Another person told us, "I rely on carers every day. They hoist me into and out of the bath twice a week and although it's not easy for me or for them they make it as comfortable as they can and just chat away. What is a difficult situation becomes a more enjoyable experience." Another person told us, "I am just so pleased the carers come to me, they are cheerful, helpful and ask if need anything else."

People told us staff had helped to improve their quality of life. One person told us, "The girls (Staff) have got me a bit mobile so that means they can take me out to the shops. They took me out last week and I got some new things. That mightn't be much to you but it means a lot to me. Another person told us, "When I was bedridden, I relied on them entirely and they never let me down. They would do anything for me whether it was creaming my legs or microwaving lunch. Nothing was a bother."

Relatives also spoke positively about the care provided to people who used the service. One relative told us their relation was provided with female carers by choice and that staff encouraged them to be independent by encouraging them to carry out the tasks they were able to. This relative also told us, "The girls (Staff) are marvellous. They do their best for them." Another relative told us, "The girls (Staff) are great, they know what to do and they know how to manage them. Nothing is a bother and they (Staff) will do whatever is needed."

From speaking with staff, we could see they enjoyed working at service and valued the people they cared for. One staff member told us, "We bend over backwards and go the extra mile for our clients." Another staff member told us, "When we attend a call, it's important that we stay for the full time. That person might not see anyone else in the day." Another staff member told us, "The care we give to clients is good. It makes a difference to their lives." The registered manager told us, "We have some lovely staff working here. We offer incentives to staff who go that extra mile."

Staff told us they involved people in their care by asking them what they needed at each visit and allowing them to make all decisions. One person told us, "I received a letter asking about my views on how things were going and I told them I'm happy with things. People also told us they were involved in planning and reviewing their own care. The registered manager told us, "We make sure everything we do is their [People using the service] choice. The way the want to do things, how they want it and when they want it." They also told us that if people were having difficulty making decisions about their care they would arrange for the person to access an advocate. This is a means of accessing independent support to assist with decision making.

People we spoke with confirmed that staff always maintained their privacy and dignity whenever personal

care and support was carried out. People gave us examples of how staff did this which included closing curtains and doors, making sure people were covered over and giving people the time they needed when care and support was given. One staff member told us, "When we assist people with their care we make sure curtains are closed, that we have towels handy and make sure we have everything we need before any care is carried out." Another staff member told us, "We make sure we close doors and cover people up. It's the things which you would do for yourself." Staff also told us that they took the time to talk with people and maintained confidentiality. "One staff member told us, "We make sure we give people the time they need. It's amazing how much people appreciate you having a chat with them." One person told us, "The girls (Staff) are all very pleasant and helpful and will have a conversation with you as well as helping you. Everything is very good and I'm quite comfortable with the way things are."

Requires Improvement

Is the service responsive?

Our findings

People had a range of care plans in place for the care and support they needed, however we found that these lacked the detail needed to provide personalised care and support to people. From speaking with staff, we could see they had a good understanding of people's needs. The lack of information in the care records meant that new staff and staff unfamiliar with people would not have the information they needed to provide the care and support people needed and wanted. We also found that people's care records were not updated when their needs changed or when they had requested specific changes. For example, we found that one person had requested a hot drink to be made when staff visited them and for their nutritional intake to be recorded because they were diabetic. From the daily records we could see that these requests were carried out however the care plan had not been updated. We found that another person received assistance with catheter care, however there was nothing in the person's care plan about this. This meant staff did not have the written guidance they needed to provide care and support to people.

People were not regularly involved in reviewing their own care. Some people told us they had not been involved in a review and other people told us they could not remember if they had received one. From people's records we could see that regular reviews of care had not been carried out. We found that one person started using the service on 5 June 2015 and was due a review of 5 June 2016; however no review had taken place. For another person, reviews had been carried out on 31 December 2013 and not again until 10 April 2015.

Not all quality reviews of care records which we looked at had been completed; we identified gaps in these records and risk assessment scores had not always been completed. This meant we did not know if people had received a full review of their care or if staff had failed to complete the records appropriately. We could also not see if people were happy with their care and if the care provided was meeting their needs. In one person's review, staff had not addressed the current risks to the person. We noted that there was no current or previous risk assessment scores despite a known risk of falls. The review did not contain any comments about care from the person or from the service.

We found that where people had requested changes in their care, records did not show if these requests had been carried out. A quality review for one person on 10 March 2016 was incomplete. We could see the person had requested an earlier morning call but we could not see what action had been taken to meet the person's request. There was no information in the care records to determine whether this request had been considered or implemented.

People who required care records in large font were not provided with them. One person was visually impaired and requested a copy of their care plan in large font. We spoke with staff and they confirm this request had not been carried out. Staff also told us that another person had requested a copy of their timetable for when staff would attend their home in large font which was not provided. We spoke with staff and were told that this was an information technology (IT) issue which they were waiting to be resolved. This meant the service did not have systems in place to provide people with care records in large font. We asked the registered manager to take immediate action to address this.

Staff had failed to complete records appropriately and take the action needed when care records did not reflect people's care and support needs. Quality assurance checks had not highlighted the concerns identified above.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

A small number of care plans looked at did containd detailed information. This meant, for these people, staff had the information needed to provide care and support which reflected people's needs, wishes and preferences. In one person's records we found detail about taking the brakes off equipment using for moving and handling, ensuring the person wears their safety pendant alarm and charging the hoist after use. This meant staff had the information they needed to provide relevant care to this person. Daily records contained information about the care and support which people had received. Staff told us that they used these records to monitor any changes in people's health and well-being.

A small number of complaints had been received by the service. These complaints related to missed calls and poor customer service. Records showed the action taken to resolve each of the complaints and the outcome. People spoken to during inspection told us they knew how to make a complaint if they needed to. No-one we spoke with during inspection wanted to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

A small number of audits had been carried out in areas such as health and safety, care records and staff files and this information was shared with the registered provider. We questioned the effectiveness of audits, because we noted gaps in some of the audits looked.

We questioned the effectiveness of audits of daily records. These were completed to check the quality of the records, to ensure calls were carried out and to ensure people were receiving the care and support needed.We found that these audits were not regularly carried out. Where they had been, only a small number of pages in each book were audited. This meant that effective auditing had not been carried out; we noted that gaps in call times and recording at call times had gone unnoticed. We also noted that one person was refusing their medicines and this had not been picked up in the audit.

A medicines audit dated 29 February to 27 March 2016 had not identified that two calls per day had not been carried out for over four week to one person. Audits of staff records and care plans had been carried out. From the audits it was clear that areas for improvement had been identified, however no action plans had been produced. Staff who had untaken these audits had failed to take action to make the improvements needed.

Quality assurance process in place at the service had not highlighted the concerns which we did during inspection. We could see that the service shared information about safeguarding and accidents and incidents with the registered provider, however they had failed to notice that staff had not been making safeguarding alerts when needed.

Policies looked at during inspection had been updated in February 2016, however we found the complaints policy referred to the Health and Social Care Act 2008 Outcome 17 for complaints. This is incorrect, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 refers to Regulations. Complaints is referred to in Regulation16 receiving and acting upon complaints. We asked the registered manager to take action to change this.

We could see that the registered manager had been asked to undertake duties in other offices within the registered provider's portfolio. This meant that this had taken them away from this service at times. We could see this had impacted upon the day to day running of the service because they had not always had the time needed to embed and support staff to change the culture and day to day running of the service. We could see that the registered manager had put procedures in place; however staff were failing to raise concerns when needed. For example, staff had failed to make the registered manager aware of potential safeguarding concerns. Staff had received training in safeguarding but had failed to follow the correct procedures. This meant the registered manager was unable to take the action needed.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The registered manager had been registered with the Commission since 30 June 2016. They were aware of their roles and responsibilities and had made notifications to the Commission when required to do so.

During our inspection, people and staff told us that the quality of the service had improved since the registered manager had started. Two people described the service as "Outstanding" and nine people described their care as "Very good." One person told us, "I feel that care has improved considerably over the past 6 months. I was not happy last year." Another person told us, "The office staff seem to be more open to what we have to say about things and seem to listen now." A relative told us, "The new manager does seem to be more approachable as I have made contact with her regarding my Mother's care." People told us communication with the office had improved. One person told us, "Calls do eventually get returned now so don't feel ignored."

We found that the registered manager was open and honest with us about the quality of the service during inspection. It was clear that they were aware of some areas of concern which we discussed during feedback. The registered manager discussed where the service was when they took on their current role at the service. From speaking with them, it was clear that significant improvements had been made. However they did acknowledge that there was further work to do. Staff told us improvements had been made since the registered manager started at the service. Staff told us the number of missed calls had improved and staff felt able to approach the manager. The local authority also told us that they had seen improvements to the service and had confidence in the registered manager to take the service forward.

The registered manager told us they were supported by the area manager and participated in weekly conference calls. They also told us they received weekly key performance indicator updates from the registered provider. From speaking with the registered manager, we could see that the registered provider did not regularly visit the service because they were needed at other services within the registered provider's portfolio. However the registered manager was not concerned with this. They told us, "If I need [regional manager] here, they would be. I can't fault the support which I have had."

The registered manager told us they had an open door policy and staff could speak to them whenever they needed to. Staff confirmed this to be the case. The registered manager told us, "It's a different place now. Staff seem happy. They used to creep in and out." They also told us, "It's important to get to know staff. I deliver care when we are short. It's important to lead by example. Staff told us they felt supported by the registered manager. One staff member told us, "I feel supported, definitely. If I have any problems I can go to [Registered] manager. She sorts it out for us." Another staff member told us, "[Registered manager] seems nice. I don't have much to do with her."

Regular staff meetings were held for staff to attend. We could see from the minutes of these meetings that safeguarding, medicine administration records, Parkinson's disease and dementia awareness had been covered. Staff told us they attended staff meetings and found them valuable. Staff told us they were not always able to attend; however minutes were made available to them. The registered provider issued a 'Weekly staff bulletin' which included information from the chief executive and included different areas each week including absence, information technology, security and medicines.

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 Risk assessments did not reflect people's needs. Staff did not always act upon risk. Medicines were not managed safely; medicines were not always taken as prescribed and there were gaps in medicine administration records.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff had failed to recognise safeguarding concerns and take appropriate action. Staff lacked knowledge about abuse and the procedure which they needed to follow. Safeguarding alerts had not been made when required to do so.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were gaps in all records looked at. Audits were incomplete and had not identified the concerns which we had during inspection. Staff failed to follow procedures when needed. There was a lack of action plans in place. There were no systems in place for DNAR certificates. Mental capacity screening assessments were carried out when people had capacity. Care records did not always match people's needs and had not been regularly reviewed. They

were not updated when changed had been identified.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all areas of staff training were up to date; staff performance records had not always been completed.