Foxenden Healthcare Ltd

Kare Plus Guilford

Inspection report

The Mews
77-88 High Street
Camberley
Surrey
GU15 3RB

Tel: 01483608855
Website: www.kreplus.co.uk/guildford

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Kare Plus Guildford provides care to people that live in their own homes. Services are provided to older people, people with mental health issues, physical and learning disabilities and sensory impairment. There were 12 people receiving a regulated activity at the time of our inspection.

People's experience of using this service and what we found
People were not always being protected from the risk of abuse as the provider had not always investigated allegations of abuse or reported them appropriately. Risk assessments were not always in place in people's care plans. Those risk assessments that were in place were generic and not specific to the person.

Although there were improvements around the management of the service, systems were not always in place to ensure smooth delivery of care. The provider failed to follow their own policies that related to safeguarding people and ensuring that staff were attending meetings where required. Staff fed back the management of the service had improved.

People were not always contacted by the office with when staff were going to arrive late for the call. Where complaints were made around lateness of calls these were not always recorded or responded to. We have recommendations to include the provider considering how people are contacted when staff are going to be late and about the recording of all complaints. There were other complaints that were investigated and responded to appropriately.

There were sufficient staff to attend calls and there had been no missed calls. Staff were adhering to good infection control. Staff had received updated training and were being supervised in their role.

Care plans contained information around people's wishes around care routines. Staff were aware of the care that people needed. Staff also communicated the needs of people through care notes and meetings. People were asked their consent before any care was delivered. Health care professionals were consulted in relation to the care delivery.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

People were treated by staff in a caring and respectful way. Staff ensured that people were supported to remain independent. Staff had developed good relationships with people and supported them to follow their interests.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Previous Inspection
The last rating for this service was Inadequate (Report published 26 February 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection although there had been some improvements the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. Prior to the inspection we received concerns that related to safeguarding incidents not being investigated or reported by the provider.
We have found evidence that the provider needs to make improvements. Please see the Safe, Caring and Well Led sections of this full report. The provider has given assurances that the safeguarding incidents that were not reported are now being investigated and have been reported to the Local Authority and CQC.

Enforcement
We have identified breaches in relation to safeguarding people from abuse, risks relating to people's care including the management of medicine and the lack of following procedures and policies. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Since the last inspection we recognised that the provider had failed to notify the CQC of reportable incidents. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

Follow up
We asked the provider to mitigate the risks in relation to ensuing that safeguarding incidents are reported and investigated.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Kare Plus Guilford

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Our inspection was completed by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Kare Plus Guildford provides personal care and support to people living in their own homes. Services are provided to older people, people with mental health issues, physical and learning disabilities and sensory impairment. At the time of the inspection 12 people were receiving a regulated activity.

The service did not have a manager that was registered with the Care Quality Commission (CQC). A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started at the service and had submitted their application to register with the CQC. They were present at the inspection.

Notice of inspection
Our inspection was announced. This was to ensure that the manager and the provider would be present at the office. The inspection took place on the 7 August 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We also checked for feedback we

received from members of the public and the local authority. We checked records held by Companies House.

On this occasion we did not ask the service to complete a Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
At the office we spoke with the provider, the manager and two members of staff. We reviewed four people's care records, medicine records, audits, recruitment records for all staff and other records about the management of the service.

We also visited three people in their homes with their permission and called and spoke with six people and three relatives of people using the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received feedback from the Local Authority. We also rang and spoke with five members of staff.

Inadequate

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure that people were protected from the risk of abuse. This was 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.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 13.

● People told us that they felt safe with staff. One person said, "[Staff] Make sure I am alright, so I am perfectly safe." A relative told us, "My [family member] is very safe with them, they are very careful and competent."
● Despite this we found that instances of alleged abuse that were reported to the provider were not always being investigated by them. This was putting people at further risk of potential abuse.
● Concerns were raised with us prior to the inspection that instances of alleged abuse had taken place. We were told that these had been reported to the provider and that no action had been taken to investigate these or report them to the Local Authority. The provider confirmed that information had been passed to them and that although some action had been taken on two of them, but no action had been taken on a significant allegation of abuse of one person. They confirmed that they had not referred any of the three incidents to the Local Authority or the CQC.
● The provider told us they recalled an incident being raised with them in either January of February 2019. This involved a member of staff being witness to an incident of potential abuse. The provider told us in relation to this allegation, "Yes it does ring a bell, but I can't remember. It must have been in the 1st quarter of this year." The provider had not recorded the details of the incident or reported it.
● Staff were able to tell of the types of abuse that could take place and what they needed to do if they suspected anything. However, where the provider had not taken action in relation to the alleged abuse staff were also not raising this with the Local Authority. One member of staff said, "I'd speak to (provider or manager) and report to the right people. In my diary I have the numbers for safeguarding and CQC, so I

could go through the right channels."
● The service safeguarding policy stated, "Kare Plus Guildford should ensure that Surrey Heath Safeguarding Adult referral process is followed and should collate the following information to assist with the referral. The referral process should be clearly visible with contact numbers, including out-of-hours, where staff can access the information." However, staff were not always following the process of contacting the relevant authority despite them having had recent safeguarding training.

Systems were not in place to ensure that allegations of abuse were investigated and reported. This placed people at risk of harm. This was a continued breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● Risks to people were not assessed appropriately to ensure that people were kept safe. The 'risk management plans' in people's care plans were short tick box checklists with space for comments. There was then a risk management plan which listed the identified risk, action taken and level of risk. This was not person centred as each person was rated as low for every risk despite there being information to indicate the risks were greater.
● One person was at risk of developing pressure sores and at risk of falling. There was no risk assessment in place that was specific to them. Although staff were regularly contacting the office where they had a concern with skin integrity there was no guidance for them to follow in the care plans. Another person had a catheter, there was no risk assessment in place that related to this. The manager told us that the risk assessments were currently generic and that they were looking to address this.
● Accidents and incidents were not always recorded which meant that analysing them to look for trends was not always possible. Staff told us that if there was an accident or incident in the person's home they would ring the office to advise them and then write this in the person's daily notes. We saw evidence that staff were reporting concerns around people's health and welfare.
● The service policy stated, "After the accident/incident investigation and all matters concerned with it are complete, a copy of the signed accident/incident form should be placed in the personnel file of any person(s) affected by the accident, and the original placed in the accident book." Staff were not following this policy. The only way to identify actions taken was to look on people's individuals' electronic notes.
● Medicines were still not always being managed in a safe way. People told us that they received their medicines. One said, "I take them, and they check that I have done." However, staff were not always recording the administration of medicine appropriately.
● There were gaps on the medicine administration record (MAR) which meant it was not always clear when, or if, people had received their medicine. The information on whether people had allergies or not had not always been completed. Where prescription information was handwritten staff were not always counter signing to ensure that the information was correct. Staff were also not signing the time the medicine was given. There was risk that if care calls were late medicines were given later than normal, and people would get dosages of medicine too close together.

● Staff had received medicine training and were competency assessed but this had not been effective in ensuring that the medicines were given as prescribed or recoded correctly.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure that staff were deployed appropriately to reduce the risk of calls being missed . This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 18.

● People told us that their calls were no longer missed and that this had improved from the last inspection. One said, "Once or twice [staff haven't arrived] but it is in the past." Staff said that they felt there were enough of them to cover the calls. One told us, "I'm mostly with the same people but like to be on hand and they could always call me."
● The provider and manager ensured that there were sufficient staff to cover each call and where there was a last minute absence this would be covered by the team leader or the manager.
●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm that new staff were safely employed to work with people.

Preventing and controlling infection
● People were protected against the spread of infection as staff were following good practices. People told us that they saw staff wear protective equipment and wash their hands regularly.
● Staff received training on the importance of good infection control. Staff were provided with stocks of gloves and aprons and were able to pick up more from the office when needed. One member of staff said. "We now sign out gloves and aprons, so they know whose got something. It's nicer for them (person) if we use them."

Requires Improvement

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This meant the effectiveness of people's care, treatment and support was inconsistent. At this inspection this key question has now improved to Requires Improvement. This meant there have been improvements in the effectiveness of people's care, treatment and support did achieve good outcomes and was more consistent.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

At our last inspection the provider had failed to ensure that they were working within the principles of MCA and there was a risk that care was being delivered without the appropriate consent. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 11.

- People told us that staff gained consent from them before they delivered care. One said, "They [staff] always ask my permission before they do anything."
- The manager was aware that they needed to safeguard the rights of people who were assessed as being

unable to make their own decisions and choices. Although there were no people that lacked total capacity to make decisions they understood that assessments of capacity needed to take place where there was a doubt for example in relation to accepting care from the service.
● Staff had received training and understood the principles of MCA in that people had a right to make their own choices. One told us, "It's to protect everyone, for their right to be a human being. Even if your mental state is different you still have a right to say no."

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had received appropriate training and supervisions in relation to their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 18.

● People and relatives felt that staff were effective in the care they provided. One person said, "My regular carer is very skilled." Another said, "They are wonderful, and very capable." A third told us, "I have a banana board to transfer from bed to wheelchair and it always feels safe with staff."
● Despite this we have identified that training needed to be more effective in ensuring that staff understood and implemented what they had been taught for example in relation to the management of medicines and safeguarding.

We recommend that the provider undertakes more comprehensive competency checks to determine that staff understand and implement their training in practice.

● Staff were provided with an induction before they delivered care. This consisted of e-learning, face to face training and shadowing another member of experienced staff. One member of staff said, "They gave me an induction and I shadowed [the senior carer] until I understood everything."
● Staff were all required to compete the care certificate [The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.] One member of staff said, I've finished the Care Certificate and completed first aid. It's all been useful. They notify us of training via emails."
● The senior carer and manager undertook group and individual supervisions with staff including spot checks in people's homes. One member of staff said, "I've had supervisions and feel close to people here so can talk to them if there are any problems."

At our last inspection the provider had failed that detailed assessments of needs had taken place before they started receiving care and health care professionals were not always consulted when there was a concern with people's health. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 9.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare

services and support

● There had been no new people taken on by the service since the last inspection. However, the manager had put in place new assessment forms, so they could ensure people's needs could be met once the decision had been made to take new people on.
● People told us that they were supported with their meals and drinks. Comments included, "They [staff] always make sure I have access to water and they do the food" and "They offer a range of choices."
● We observed that staff ensured that people were offered a choice of meals and that before they left the call they had sufficient food and drink left with them.
● When staff had a concern with a person's health they ensured that the appropriate health care professional was consulted. One person told us, "I know that they are keeping an eye on me when they visit." Another said, "My legs break out in sores occasionally and they make sure if that happens they report it to the office who call my Doctor." On the day of the inspection we heard a member of staff from the office contacting a GP in relation to a concern they had.
● Staff worked with professionals to support people with their healthcare. We saw that any concerns that related to skin integrity were report immediately to the district nurse to review.

Requires Improvement

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. There were however still areas for improvement that ensured that people felt well-supported and communicated with. People were cared for with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care;

At the previous inspection there were times when calls were missed, people did not always know what carer was attending and people were not always involved in their care planning. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had been improvements made and the provider was no longer in breach of regulation 10. However, there were still improvements that related to the times people received their calls and the communication to people where care staff were going to be late.

● People told us that although staff always attended the call they very often were late, and they were not always notified of this. One person told us, "I have to ring and find out what is happening." Another told us, "Sometimes I have to wait for quite a long time for my meals, particularly at breakfast. This happens two to three times a week roughly." A relative told us, "It's just frustrating at times, Staff should be here at 09:05, but often don't turn up until 09:45. This has us running late or having to rush." A member of staff told us they, "Sometimes worry about late calls which are sometimes an issue."

We recommend that the provider puts in place systems so that staff are rotered on to provide care for people at a time that has been agreed and that people are contacted if staff are going to be late.

● People told us that there were aspects to the care delivery that they felt involved in. One person told us, "I asked for mature carers and that is what we have." A relative said, "[Their family member] likes an afternoon nap and once I have explained they [staff] do things as he wants."
● People and relatives were involved in their planning of care and reviews. One person said, "We discuss [my care] during care call as my husband is there as well."

Ensuring people are well treated and supported; equality and diversity

● People and relatives told us they had positive relationships with staff and that staff were caring. Comments included, "They [staff] are a delight and it is their conversation that is getting my wife better", "They are all friendly" and "Absolutely lovely and friendly."

● We observed caring interactions in people's homes. When staff entered people's home they greeted the person warmly and asked how they were. There was laughter and chatting between people and staff and you could see that people were relaxed in staff company.

● People fed back that staff knew what was important to them. One told us, "They [staff] are very good at looking after me and watering my plants." This was of value to the person who had a number of plants in their room that they could look at while they were in bed.

Respecting and promoting people's privacy, dignity and independence:

● People and relatives fed back that staff treated them with respect. One person told us, "They [staff] are very empathetic, they know I am not a morning person and they respect that." Another told us, "I would send them packing if they didn't [treat them respectfully]. They call me by name and they remember things about me between visits."

● We observed staff treated people in a dignified way. One person we visited was supported to wear colour co-ordinated tops and trousers. They were wearing jewellery and their hair was neat and tidy. Each time the member of staff spoke with them they ensured that they made eye contact with them.

● Staff provided personal care behind closed doors and people told us that staff treated them in a dignified way. One person said, "They [staff] always talk to me as an individual and not down to me because I am in a wheelchair." A relative told us, "They are treating my wife as an individual and respect her past life as well as her present."

● We saw a member of staff sat on a person's armchair but respected that the person was watching the television. The member of staff saw that the person was clearly interested in the programme, so did not interrupt them with conversation too often.

● People were encouraged with their independence. One person told us, "Member of staff asked if I wanted to go out, I said no at first, but she encouraged me to go out, which I then really enjoyed, I'm glad she helped me." Another told us, "I get taken out to the garden and I try to do things for myself, they are very encouraging." A member of staff said, "Anything [person] can do herself she does, and I wait for her to tell me when she wants help. With some people it's just being there in case they need help and letting people be as independent as they can."

Requires Improvement

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. People's needs were met through good organisation and delivery. However, improvements were needed to ensure that care plans had the detailed information around end of life care and how complaints were recorded and responded to.

Improving care quality in response to complaints or concerns

At the previous inspection we found that complaints were not always recorded and responded to. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had been some improvements made and the provider was no longer in breach of regulation 16. However, there were still improvements that related to the complaints that related to missed calls not always being recorded and analysed.

● There were a mixture of responses relating to whether people felt their complaints were listened and responded to. One person told us, "I complained about my box of gloves that I like to keep under my bed being taken away by the carers, it was just brushed away and not dealt with." Another told us, "If I have a problem I ring [the provider] and he sorts it out straight away."
● The main theme around complaints people told us they made were about staff arriving late and they were not always notified of this. When we checked the complaints folder these were not being routinely recorded. The service policy stated, "A full record will be held of all complaints received regardless of the level of seriousness and means of communication. This approach allows an open and transparent culture around raising concerns in the earliest stage to allow resolution. A record of the complaint will also be held in the service user's care file and reported in line with contractual or regulatory requirements." We found that this was not always happening.

We recommend that the provider records all complaints made by the people at the service according to their policy.

● There were complaints that had been investigated thoroughly and people and their relatives were

satisfied with the response. For example, one person complained that their call had been cut short due to a confusion over how long the call was planned for. The provider refunded the person the cost of the call and the provider met with the person to discuss the specifics of how long they wanted their call to be.
● Another person complained they wanted consistent staff for their call. The provider planned for the rota to be organised to ensure only specific staff attended the call.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

At the previous inspection we found that are and treatment was not always provided that met people's individual and most current needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 9.

● Care plans were now more personalised and included information on how staff could support them with their needs. One person told us, "They [staff] do exactly what I want them to do." A relative told us, "I came home early the other day and they [their family member and the member of staff] were doing Karaoke together in his bedroom, they were having a great time"
● Staff were aware of the care that people preferred. When speaking about one person a member of staff said, "I like to go [to the person] and they are very friendly. She likes her routines, so you need to keep up with her. I know her care and she will have a little chat now and then. She loves her jewellery collection and she knows what she likes."
● Care plans contained information on people's preferred routines and their likes and dislikes. For example, one person's care plan stated, "Need help to do exercises before getting out of bed. Help with personal care and then if time sit and chat to aid communication." Staff recorded people's care in daily diaries to ensure that staff attending would know what care had been delivered. The daily records matched with the person-centred care plans.
● There were no people at the service that were receiving end of life care. However, we saw evidence in people's care files end of life care planning was discussed with people and the recorded comments reflected that people weren't ready to talk about it or would discuss with family.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Each care plan detailed how best to communicate with the person. One person's care plan stated that they had a particular medical condition that affected their speech. The care plan gave details on how staff needed to support the person by encouraging conversation.

Inadequate

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there remained shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the previous inspection we found that there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● Prior to the inspection we were given information that related to alleged safeguarding incidents that the provider had not reported to the Local Authority or the CQC. When we spoke with the provider they confirmed that these were raised with them, but they had not taken action to report them or always investigate them. Despite the provider already having paid a fixed penalty notice for having failed to report notifiable incidents to the CQC.
● The service safeguarding policy stated, "By law, Kare Plus Guildford And Farnborough must notify the Care Quality Commission without delay, incidents of abuse and allegations of abuse, as well as any incident which is reported to or investigated by the Police." We found that the provider was not following their own policy.
● Staff were required to attend meetings at the service to discuss matters such as policies and training and to gain their feedback. However, we identified that not all staff were attending despite the service policy stating, "As part of this [Kareplus] framework, staff will be expected to participate in contributing their views and feedback that will influence the quality framework and therefore the quality care that service users receive." One member of staff told us that they were aware of the meetings but chose not to attend. The

manager told us that they had been trying to address this with staff.
● We asked for minutes of all staff meetings that had taken place. To date we have only been provided with an attendance sheet of staff that attended and the agenda. We can see that not all staff had attended the meetings which meant that there was a risk that staff were not being provided with important management information.
● Staff told us that although communication had improved they still had concerns. One told us, "It's particularly out of hours. You send emails [to the office] but they don't always reply." This was a theme from staff we spoke with in terms of the lack of response to emails.

As systems and processes were not always operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At the previous inspection we found that notifications were not always being sent to the CQC where required. This was a breach of regulation 18 ((Registration) Regulations 2009.

At this inspection not enough improvement had been made and the provider was still in breach of this regulation.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Prior to this inspection we were notified of concerns that related to safeguarding incidents. These at the time had not been notified to us by the provider. The service policy states that, "By law, Kare Plus Guildford must notify the Care Quality Commission without delay, incidents of abuse and allegations of abuse." Whilst on the inspection we identified three incidents of safeguarding that had not been notified to the CQC. This was despite the provider paying a fixed penalty notice in relation to this from the last inspection.

As notifications were still not always being sent in to the CQC this is a continued breach of regulation 18 of the (Registration) Regulations 2009.

Continuous learning and improving care; Working in partnership with others; How the provider understands and acts on the duty of candour , which is their legal responsibility to be open and honest with people when something goes wrong;
● A new manager had started at the service in April 2019 and had been instrumental in making improvements. They had ensured that staff were completing more face to face training and that staff were being supervised more in their role. Staff fed back that they had seen improvements since the manager had started. One told us, "I do feel that they are listening more now." Another said things had, "Improved vastly" and that they felt, "100% supported and could tell [the manager] anything."
● Staff that had attended meetings said that they were beneficial. One told us, "We can put our opinions across and we now feel as though our opinions matter." Another told us, "Since [the manager] has been here he has been a lot more on the ball with everything. The communication was bad when I started but since he's been here it's been much better."
● The manager had picked up on shortfalls that we had identified and had been working hard to address these. There were quality assurances systems in place that were effective in ensuring quality of care. We saw that people were called by a member of the office staff to ask them if they were happy with the care. Audits were also being undertaken to check that staff were completing daily records and that they were staying for the full length of the call. The manager informed us audits were also being undertaken of the MARs and they were working on the concerns identified.
● Steps were being taken by the manager and the provider to drive improvements and they worked with external organisations to help with this. There was regular contact with the district nursing team where they

had any concerns with a person's skin integrity. Other health care professionals from the Clinical Commissioning Groups (CCG) were also supporting the service with aspects of the management of medicines.